CANADIAN GOVERNMENTAL
REPORT ON AGING

June 1982

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FOREWORD

The decision by the United Nations to convene a World Assembly on Aging from July 26 to August 6, 1982, presented a challenge to Canada to review the current situation regarding her older citizens, and to consider the kinds of future developments that may be required to meet the needs and aspirations of an aging population. The Canadian Governmental Report on Aging represents a fundamental step in the process. Therefore, in this year of the first World Assembly on Aging, during the month of June which has been declared Senior Citizens' Month in Canada for 1982, I am dedicating this report to the aged of Canada - past, present and future.

The aged have contributed greatly to the building of our country; they will continue to shape it in the years to come. Over the years, in recognition of their participation and to help them continue as an integral part of Canadian society, services have been developed for them. If there is a collective desire to improve the services offered and perfect our support systems, it derives from a recognition of the scope and significance of the contribution made by each citizen, particularly those who reach an advanced age. These elderly persons have been instrumental in awakening our awareness of their present and future needs. In expressing their concerns, their satisfactions, and their hopes Canada's senior citizens guide us; they direct our steps and light our paths. It is my hope that they will find their thoughts and ideas reflected in this report. It is also my hope that older Canadians will continue to participate in matters of concern to them.

The initial purpose of the report is to serve the Canadian delegation to the World Assembly on Aging. Equally important, however, will be its usefulness to Canadians who are engaged in matters pertaining to aging and the aged. Complementing the governmental report is the report prepared by the National Advisory Council on Aging presenting the views of the non-governmental organizations.

The preparation of the Canadian Governmental Report on Aging was a co-operative effort between federal, provincial and territorial governments. Central to the achievement was the Federal-Provincial/Territorial Committee for the World Assembly on Aging, with its members appointed by the deputy ministers of health or of social services in the respective jurisdictions. Its mandate was to produce a report which would be in accord with the perspectives of the governments concerned.

The provincial and territorial representatives devised their own methods to get input from the various departments and governmental agencies within their purview concerned with the issues to be addressed. Federally, two committees were established to contribute to the co-operative effort, namely, a committee within the Department of National Health and Welfare and an interdepartmental committee representing the Departments of Employment and Immigration, External Affairs, Finance, Health and Welfare, Indian Affairs and Northern Development, Labour, Secretary of State, Statistics, Veterans Affairs, and the Ministry of State for Social Development, Canadian Advisory Council on the Status of Women, Canada Mortgage and Housing Corporation, Treasury Board, and the Privy Council Office.

My Department was given the responsibility of drafting material for submission to the three committees for review. The document, which was ultimately produced by the Federal-Provincial/Territorial Committee, was approved by each of the governments involved.

To all my colleagues, federal, provincial and territorial, whose departments or agencies have aided in developing the Canadian Governmental Report on Aging, I extend my sincere appreciation. Further, to those who have devoted their time, skills and expertise in its preparation, with particular mention of those who served on the Federal-Provincial/Territorial Committee, I offer my warmest thanks.

Monique Bégin

Monique Bégin
Minister of National Health and Welfare
and Head of the Canadian Delegation
to the World Assembly on Aging

June 29, 1982

PREFACE

An understanding of the structure of this report may serve to enhance its usefulness to the reader. The Preamble provides an overview of developments in Canada and the milieu within which an aging population is evolving. The report itself is divided into four main sections - the demographic aspects of the aging population, the humanitarian issues, the developmental issues, and research and education.

The humanitarian issues consider the specific needs of the aging. They are dealt with under seven subject areas, namely, income security, labour/employment, health, housing/environment, the family, social welfare, and education/culture/recreation. The sections are set forth in the order shown.

For the purpose of this report, developmental issues are those which arise as a result of the effects of an aging population on society and the effects of a changing society on the aging. These are handled under three subject areas - economic, social, and political - and appear in that order.

Research, and the education and training of both researchers and those engaged in service delivery, cut across all areas of concern whether humanitarian or developmental. A section specific to research and education has, therefore, been produced to avoid unnecessary duplication.

The impossibility of describing within the text of each of the humanitarian sections the many programs and services for the aged developed in the provinces and territories was recognized. The reader is referred to the Appendix where these have been set up for easy reference according to jurisdiction.

It should be noted that for the World Assembly on Aging those aged 60 and over have been designated "the aging". In the Canadian context, since 65 is considered the usual age of retirement, in this report when terms such as "the aging", "the aged", "senior citizens", and "older persons" are used, they refer to those aged 65 and over unless otherwise specified.

PREAMBLE

The convening of the World Assembly on Aging marks a recognition that socio-economic development and the age structure of a population are interrelated issues. The implications of aging for individual well-being and of an aging population for economic growth were recognized in Canada in the years after World War II and led to major advances in the provision of social security for the aging. In 1950, the Joint Committee on Old Age Security of the Senate and House of Commons of Canada described the complexities of the issue:

> "We are dealing with a phenomenon, the aging process, which is not the same for all individuals. Some persons become aged many years before others in the same community; others retain the physical capacity and ability to continue in productive employment for many years beyond what is normally considered the age for retirement ... regardless of the age which may be selected as normal for retirement, the magnitude of the problem and the numbers of persons in the population above the selected age do not remain static. Due to improved health services and the consequent increase in the longevity of our population, along with other factors, our aged population is growing from year to year ... increasing emphasis should be placed on efforts to remove from people's minds the idea that there is any set or accepted age for retirement ... Not only is this a matter of importance to individuals themselves in terms of their health and mental outlook, but it is of even greater importance to the over-all economy of the country ... The Committee has also been faced with an impressive volume of evidence which demonstrates that old age security does not consist solely of the assurance of adequate cash income to individuals in their later years ... Adequate housing, health and welfare services, the availability of suitable part-time occupations for the aged -- all these factors enter into the complex picture of the needs of this important section of the nation's population."

Canada, like other developed and developing nations, is committed to development in order to improve the well-being of all Canadians on the basis of their full participation in the process, and the equitable distribution of its benefits. Specific sectoral policies in regional economic development, social security, and immigration, to take only a few examples, are the means by which the general policy of development is implemented. While Canadian policy has never attempted specifically to influence the age structure of the population, certain policies do influence the age structure, and a changing age structure in turn affects the impact of these policies on the broad goal of development.

A traditional Canadian policy for promoting development has been immigration, and this has influenced the age structure of Canada's population. Immigration to Canada in the early decades of this century, in which there was a predominance of men, and large numbers of male war casualties in two World Wars in some of the more developed countries, have contributed to a sex ratio closer to equality among the Canadian aging than in the more developed countries as a whole. The high levels of immigration after 1945, recalling that immigration usually has a predominance of young people, coupled with the influence of the baby boom in Canada, have resulted in a younger population in Canada relative to other more developed countries. With the decline in immigration levels, the Canadian population age structure will come to resemble more closely that of the more developed countries as a whole. It is expected that 10 per cent of Canadians will be 65 and over in 1985, compared to 10.9 per cent in more developed countries, and four per cent in less developed countries. By 2000, these figures are expected to be 11.7 per cent for Canada, 12.8 per cent for more developed countries, and 4.6 per cent for less developed countries.

Certain communities in Canada are characterized by a high proportion of aging persons. This is particularly true of small urban centres in the Canadian Prairies. Urban centres with a population under 10,000 in Manitoba had 15.6 per cent of their population aged 65 and over in 1976, and such centres in Saskatchewan had 17.6 per cent of their population aged 65 and over. This age category made up 14.8 per cent of the rural non-farm population in Saskatchewan.

Using the percentage of the population aged 65 and over as an index of the age of a population, Canada's somewhat anomalous age structure can be illustrated in more detail. The developing nations have youthful populations compared to the developed nations, and the more developed of the developed countries tend to have the oldest populations. All the developed regions, as defined by the United Nations, with the exception of Japan, had older populations than Canada in 1975. In particular, Canada's 8.5 per cent was exceeded by Western Europe's 15 per cent and Northern Europe's 13.7 per cent. This can be compared to 7.3 per cent for temperate South America, the oldest population among the developing regions, and 3.8 per cent for developing regions as a whole.

Provision for the needs of the aging must be seen in the context of the economy and society which are the ultimate sources of that provision. Canada is a developed nation with a mixed market economy. As the country is highly urbanized, a majority of the aging reside in an urban setting, although many still live in rural and isolated areas. It possesses two official languages and two predominant cultures, French and English. It is a pluralist, ethnically diverse society in which immigrant communities play an important role. Immigration since World War II has created unique links between Canada and many third world countries.

As a developed nation, Canada is characterized by a relatively high per capita Gross National Product, a relatively extensive manufacturing sector, an extensive transportation and communications network, a relatively high average level of education, and a highly urbanized population. At the same time, it possesses certain attributes of a developing nation. Capital imports and natural resource exports are more important in the Canadian economy than is typical of developed nations, as is foreign trade in general. The territory of Canada is very large, with a comparatively small population highly concentrated along the border with a much larger nation, leaving large areas sparsely populated.

The original peoples of Canada, now a small minority, are widely scattered across the country, are less urbanized than the remainder of the population, and face problems of development more like those of the populations of developing than of developed nations. Although many have assimilated in varying degrees into the dominant culture, some still maintain their traditional way of life. The age structure of these populations is more like that of developing nations, with proportionately fewer aging than in the rest of the Canadian population.

Canada, like most other developed nations, has traditionally met the needs of the aging on the basis of an expectation that individuals or family heads would be in the labour force before a certain age and out of it after that age. This, of course, is the expectation most directly challenged by the changing age structure of the population and the increasing recognition of the undiminished capacities of most aging persons. Both the structure of the labour force and of the social security system could be affected by these changes.

The Canadian social security system is the outcome of a positive social policy by all levels of government, federal, provincial, and municipal, which seeks to identify the needs of the people and develop the instruments to meet those needs, with the goal of progressively raising the quality of life of all Canadians. Although constitutional responsibility for social services, health care, and education rests with the provinces, the federal government has historically participated in these areas through the use of its spending power. In the field of old age pensions and supplementary benefits (including survivors' and disability benefits irrespective of age), the federal Parliament has jurisdiction to legislate, but provincial legislation on these subjects takes precedence over federal law.

In order to compensate for unequal tax bases in different provinces, the federal and provincial governments negotiate transfers of revenues from the federal government to the provinces. The federal government also makes payments to individuals. The purpose of the federal government is to equalize opportunity for individual Canadians, to equalize the resources available for provincial public services as between provinces, and to establish national levels of social security. Where the field lies within the jurisdiction of the provinces, the programs which benefit the public are created by the legislation of each province and are administered by the province.

Although it is made up of diverse elements, Canada's social security system is comprehensive, absorbing about 14 per cent of the Gross National Product in 1976. It is based on principles of income support, community responsibility, equity, and social insurance. An effort is made to avoid the creation of artificial barriers, such as age, to needed benefits, while at the same time adapting services to meet the needs of specific groups, of which the aging is one. Responsibility for meeting the needs of self and family rests first and foremost with the individual. The acceptance of the principle of shared responsibility, when hazards occur which overburden the individual and family, has resulted in the development of mechanisms that allow the community and governments at all levels to respond. The provision of essential services is therefore pluralistic, involving all levels of government, the individual, the family and the voluntary sector. Voluntary action to meet social needs is highly developed in Canada, and the principle is strongly supported by Canadian society and governments.

Canadians are deeply committed to a society in which individuals and families can realize their fullest potential, and to creating the conditions which will allow the progressive increase of that potential. Over the years they have increasingly accepted that human potential cannot be bounded by chronological age. The majority of the aging are healthy, and therefore neither disabled nor dependent. The independence of the family and the individual is important to Canadians, and the aging will expect in the future, as they have in the past, to be able to remain in their own communities, living in their own homes for as long as feasible. Increasingly, the benefits to individuals and therefore to society which accrue from a commitment to increase physical fitness and well-being, a positive outlook, and full participation in society, are being recognized and promoted.

As an indivisible aspect of its commitment to development, Canada is striving to guarantee a more meaningful role for the aging in society and in the programs which benefit them. As Canadian society ages, it can be expected that all levels of government and the private sector will need to consider the allocation of more resources or the reallocation of existing resources so as to ensure the realization of a productive, independent, and dignified life for the aging.

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THE DEMOGRAPHIC ASPECTS OF THE AGING POPULATION: A SUMMARY

This section is a summary of a text "Background Paper on the Demographic Aspects of Population Aging in Canada". Its purpose is to portray some of the principal features of population aging in Canada and describe some of the attributes of the older population including aspects of the intra-national diversity within Canada.

There are different definitions of the phrase "population aging". The most common one is used here, namely: "population aging" means an INCREASE in the proportion of older people in a population. To use this definition it is necessary to specify an arbitrary cutting point below which people are excluded from the count of older population. This text will focus on the "age 65" cutting point, although some data are provided using the "age 60" value.

There were roughly 3.2 million Canadians at least 60 years old as of June 1, 1980. Of this figure about 2.3 million were aged 65 and over. If Statistics Canada's projections are reasonably correct, the turn of this century will find some 4.5 million Canadians aged 60 and over, and 3.4 million within this group will be at least 65 years old (see Table 1). By 2025, when most of the baby boom generation will be at least 65 years old, about 5.5 million Canadians will be aged 65 or more (barring any catastrophe between now and then).

Especially rapid growth is expected for the population at least 80 years old between 1980 and 2000. There were roughly 436,000 such Canadians at mid-1980, and they should be at least 777,000 strong at the end of this century.

By the year 2000, nearly 12 per cent of Canada's population is expected to be at least 65 years old and that would be an increase of two percentage points over the 1980 value of 9.5 per cent (see Chart 1). Whether population aging will accelerate in the early years of the next century is at present uncertain. The chief source of uncertainty results from the inability to be confident about what the children and grandchildren of the baby boom generation will do with regard to family building.

The largest numbers of senior citizens are to be found in Ontario, Quebec and British Columbia, with Ontario having by far the largest proportion, nearly 37 per cent at the time of the 1976 census. At that time 36 per cent of the older population resided in urban centres of 500,000 or more in population (29 per cent in the big three Census Metropolitan Areas of Toronto, Montreal and Vancouver).

A number of provinces (in particular, Manitoba and Saskatchewan) have small towns where the percentages of population aged 65 and over are as high as those associated with countries such as Sweden. During the 1960s and 1970s, some of the fastest rates of population aging within Canada took place among small towns.

Several ethnic groups had percentages of population aged 65 and over that were substantially above the national average in 1971. These included Czech and Slovak, Finnish, Jewish, Russian and Scandinavian.

One of the most striking features in the changing profile of Canada's older population is the substantial and growing imbalance in the number of men and women. In the first half of this century men outnumbered women slightly within the older population. Since 1961 women have been the more predominant of the two sexes in the population aged 65 and over. The Statistics Canada projections envisage continued increases in the female predominance within the older population (see Chart 2).

There is a steady rise in the ratio of men to women in the older population, starting with the largest urban centres and moving towards the small towns, and then to the rural non-farm areas and rural farm areas. In 1976, urban centres of 500,000 or more in population had only 66 men per 100 women in their aggregate population aged 65 and over (the national figure was close to 78 men per 100 women aged 65 and over). Both the rural non-farm and the rural farm areas had more men than women in the older popoulation.

Most of the literature that deals with dependency ratios relies upon the notion that dependants constitute a kind of economic burden. Unfortunately a simple statistically useful definition of "dependency" which embraces this viewpoint is not available. The most common, but perhaps the most defective, statistical indicators of dependency are based solely on the number of people in different age groups. The "population dependency ratio" relates the aggregate of older people and children to the remainder of the population; while the "old age dependency ratio" relates the number of older people to those in the prime working ages.

The population dependency ratio has shown strong declines since the 1960s, partly due to the continuing baby depression. If Statistics Canada's projections are reasonably correct, the declines will continue to a trough that may be reached only after the turn of this century (see Chart 3). Only after the baby boom generation enters the current peak ages for retirement do the projections suggest a future sustained upturn in the ratio.

Throughout the post-war period the old age dependency ratio has been rising gradually (see Chart 3). The projections suggest that from the mid-1990s to about 2006, there will be no substantial rise in this ratio. After the baby boom generation penetrates the 65-and-over age range, the ratio will start to climb upwards.

There is substantial provincial variation in the old age dependency ratio. Generally, the ratio is highest in the Maritime provinces and in Manitoba and Saskatchewan. The highest ratio is observed in Prince Edward Island.

Over half of Canada's women aged 70 and over are widows. In sharp contrast, less than one quarter of the men in this age group are widowers. Also, the proportion widowed among women aged 70 and over increased slightly between 1961 and 1976, whereas among men the corresponding proportion declined. Rates of remarriage among older men who have been divorced or widowed have been rising gradually.

Women living alone comprise a major segment of the households headed by older people. The rate at which older widowed or divorced women have opted (either by free choice or by "unavoidable necessity") for living alone has increased substantially since the early 1960s. Among women aged 65 and over, the proportion living alone has increased from about 15 per cent in 1961 to nearly one third in 1976. It should be noted, however, that once the age of 80 is reached the propensity to live alone declines sharply and there is an increasing resort to "collective households".

The tendency for health impairments and disability to be more prevalent among senior citizens, especially those over 74 years of age, than in the rest of Canada's population is strongly confirmed by the data just recently published from the 1978-79 Canada Health Survey. These data show that days of disability, percentage of population having limitation in major activity and percentage reporting at least one health problem, among those aged 65 and over, are far above the national averages. The highest proportions are observed in the population aged 75 and over.

Directly related to these patterns of reported health impairment and disability is the substantially greater than average use of hospital and medical services in the older population. Once again, the peak health service utilization rates occur above the age of 75.

Senior citizens comprise a group with an unusually high concentration of people with low income (see Table 2). This is particularly the case among unattached older women. About one half of the income of older unattached women comes from the Old Age Security and Guaranteed Income Supplement payments. Even among older men this is the largest single source of money income.

The older population has higher than average home ownership rates but they are more likely to own homes built before 1945 and the median value of their homes is substantially below the overall median value of all dwellings. Ownership of facilities such as automatic washers, automobiles and record playing equipment is below average for households headed by older people; however, the gap is very narrow for television ownership.

The labour force participation rates of men aged 55 and over have been in decline since the middle of the 1960s. In contrast, women aged 55-64 have shown rising labour force participation rates between 1966 and 1980 and the rates for women aged 65 and over have decreased by less than two percentage points. Within the older age group, the labour force participation rate is by far the highest for men and women aged 65-69, and it drops off rapidly after age 70.

Opportunities to work part-time are very important to the employment of senior citizens. In 1980, 25 per cent of employed men and 47 per cent of employed women aged 65 and over worked part-time, compared to only three per cent of employed men and 24 per cent of employed women aged 55-64. From 1971 to 1980 the per cent of older employed people working part-time increased slightly.

Table 1

Population in Selected Age Groups, Canada, 1950 to 1980 and Projections 1985 to 2025

(Population in thousands)

Year	All Ages	60 and Over	65 and Over	80 and Over
		Estimates		
1950	13,712	1,552	1,051	149
1955	15,698	1,737	1,215	174
1960	17,870	1,928	1,358	214
1965	19,644	2,150	1,507	272
1970	21,297	2,448	1,696	327
1975	22,697	2,829	1,938	375
1980	23,936	3,217	2,282	436
		Projection 1		
1985	25,971	3,654	2,551	498
1990	27,751	4,051	2,931	595
1995	29,353	4,352	3,225	709
2000	30,723	4,583	3,432	790
2005	32,001	4,974	3,581	904
2010	33,306	5,634	3,887	968
2015	34,618	6,385	4,443	994
2020	35,829	7,253	5,074	1,016
2025	36,823	8,027	5,786	1,137
		Projection 4		
1985	25,196	3,622	2,529	496
1990	26,346	3,999	2,894	590
1995	27,259	4,278	3,171	700
2000	27,938	4,482	3,361	777
2005	28,470	4,838	3,489	886
2010	28,920	5,445	3,767	945
2015	29,270	6,115	4,279	967
2020	29,463	6,888	4,844	982
2025	29,462	7,570	5,479	1,094

Source: Statistics Canada, 1973, Catalogue 91-512; 1979, Catalogue 91-518, Table 5; 1979, Catalogue 91-520, projections 1 and 4; and 1980 estimates from the Demography Division.

Table 2

Incidence of Low Income* Among Families by Age of Head and Unattached Individuals by Age, Canada, 1979

(Estimates based on revised low income cut-offs)

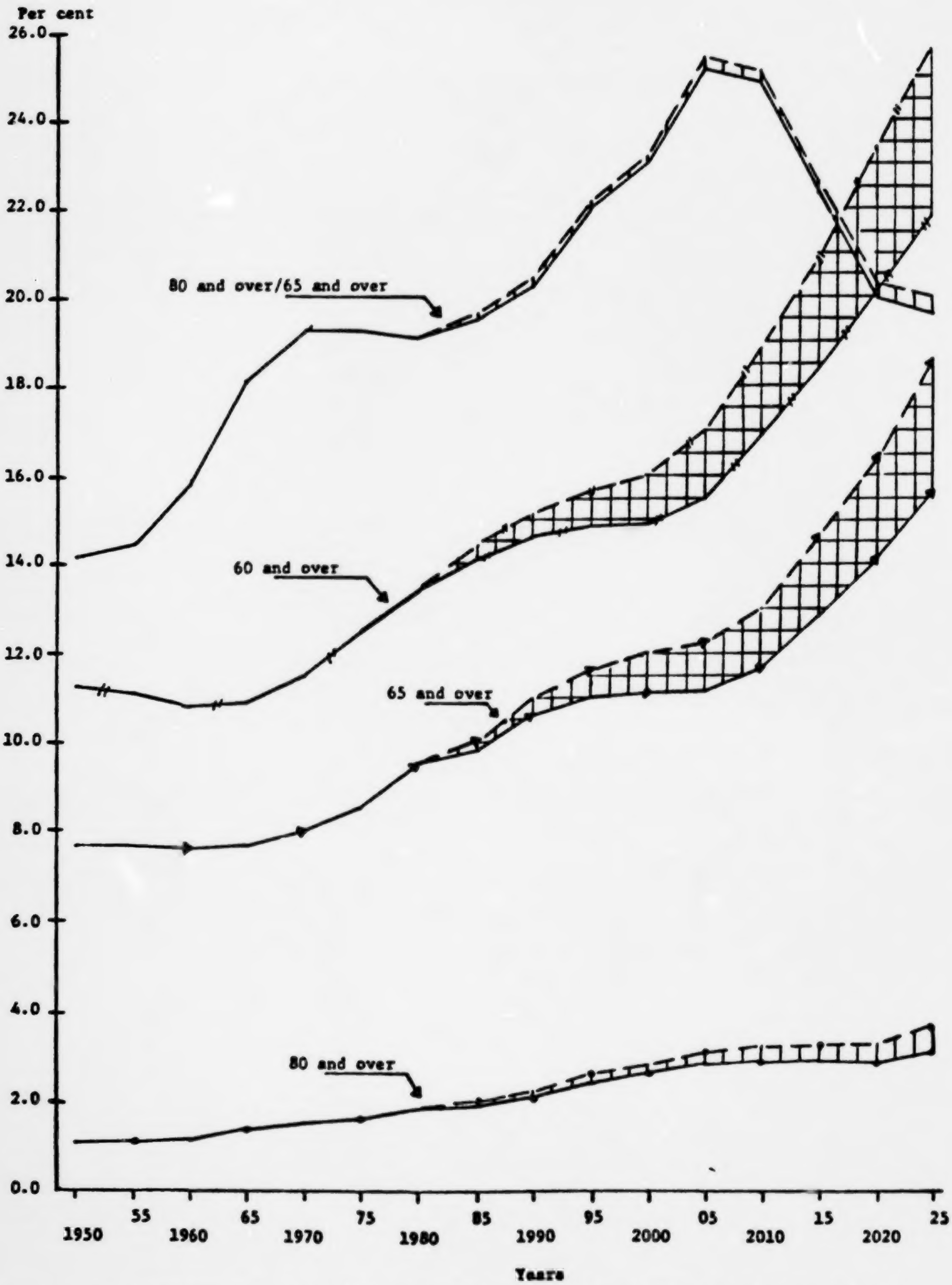
Age Group	Families	Unattached Individuals
24 years and under	18.1	30.7
25-34 years	10.3	13.0
35-44 years	9.0	18.0
45-54 years	7.6	28.1
55-64 years	9.7	39.6
65-69 years	15.5	44.3
70 years and over	14.4	52.6

*The precise value below which income is considered to be "low" varies depending on family size and place of residence. (See page 20 of the source document.)

Source: Statistics Canada, 1981, Catalogue 13-207, Table 86.

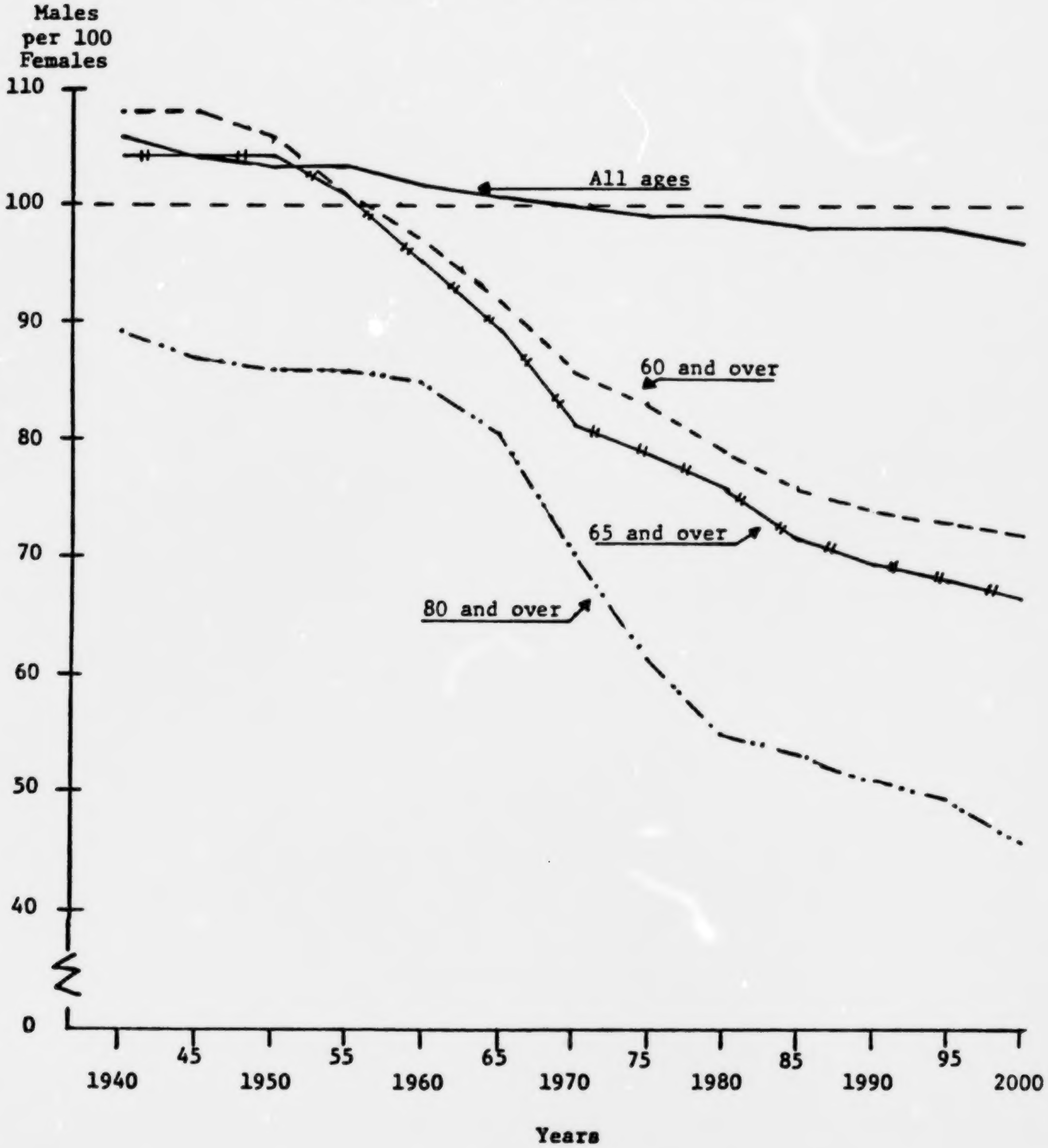
Chart 1

Percentage of the Total Population in Selected Age Groups and the Percentage Aged 80 and Over Within the 65 and Over Population, Canada, 1950 to 1980 and Projections 1985 to 2025



Source: Statistics Canada, 1973, Catalogue 91-512; 1979, Catalogue 91-518, Table 5; 1979, Catalogue 91-520, projections 1 and 4; and 1980 estimates from the Demography Division.

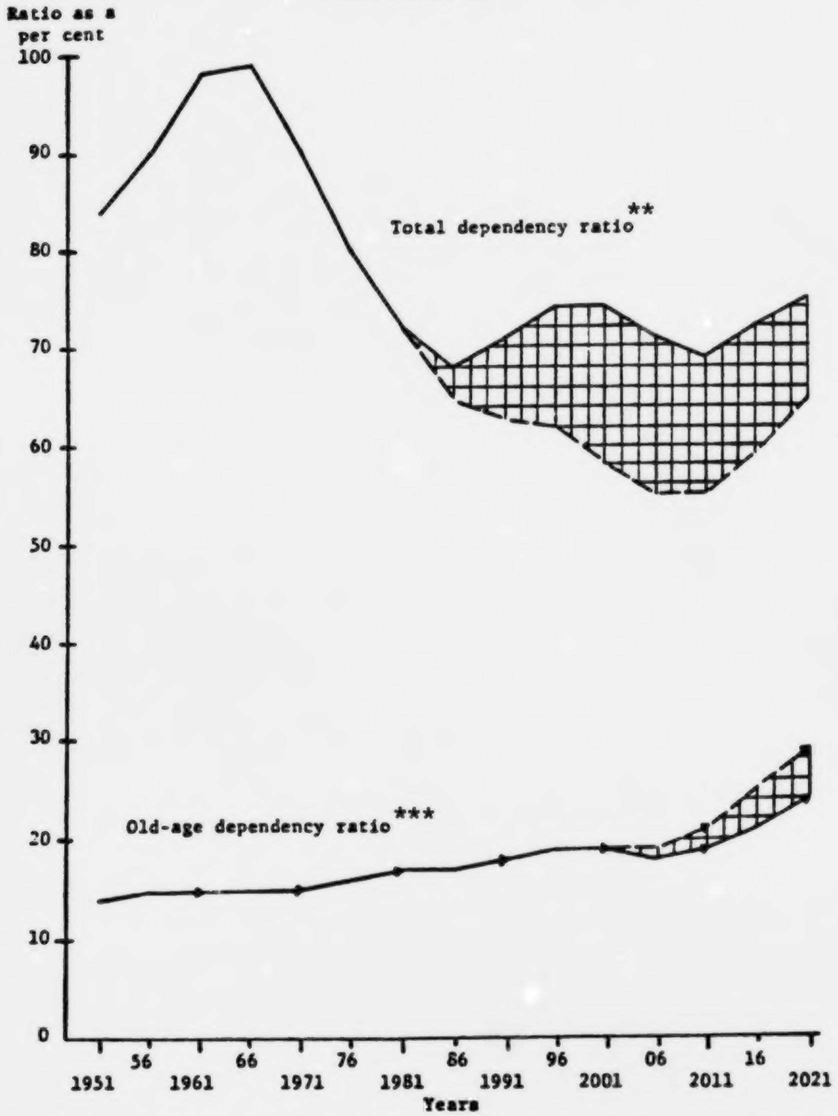
Chart 2
Ratio of Males to Females in Selected Age Groups, Canada, 1940 to 1980 and Projections 1985 to 2000



Source: Statistics Canada, 1973, Catalogue 91-512; 1979, Catalogue 91-518, Table 5; 1979,Catalogue 91-520, projections 1 and 4; and 1980 estimates from the Demography Division.

Chart 3

Population Dependency Ratios, Canada, 1951 to 1981* and Projections 1986 to 2021



* The data for 1981 are estimates based on official Statistics Canada 1980 estimates and 1981 projections.

** The total dependency ratio is defined as: [(population 0-19)+ (population 65+)]/(population 20-64).

***The old-age dependency ratio is defined as: (population 65+)/(population 20-64).

Source: Statistics Canada, 1973, Catalogue 92-715, Bul. 1.2.-3, Table 7; 1978, Catalogue 92-823, Bul. 2.4, Table 11; 1980 estimates from the Demography Division; and Senate of Canada, 1978, Proceedings of the Special Senate Committee on Retirement Age Policies, Issue No. 6, Nov. 30, Table 3.1.

HUMANITARIAN ISSUES

Income Security

Labour/Employment

Health

Housing/Environment

The Family

Social Welfare

Education/Culture/Recreation

INCOME SECURITY

A PERSPECTIVE ON THE INCOME OF THE AGING

The incomes of the aging in Canada come from a variety of sources: employment, government transfer payments, pensions, savings and investments, inheritances, lump sum settlements of property and life insurance plans, and the occasional windfall gain. But non-money sources of income in the aging population are significant. One estimate* suggests that receipts-in-kind and the provision of housing and other services by children and other relatives can add up to 30 per cent more to the reported income of the aging. Primarily, however, this additional 30 per cent arises from transfers to married women by their spouses. The result is that while non-money incomes of the unattached aging may be significant, they are probably not very high, especially if one excludes those in institutions.

Table 3 shows the relative contribution from different income sources to the incomes of the aged in 1979 with source data from the Survey of Consumer Finances (SCF).

In 1979, some 40 per cent of unattached aging persons (about 366,000) and 11 per cent of older couples (about 37,000) had incomes below Statistics Canada's (1969-based) low-income cut-offs.** What is disquieting about such figures is that the proportions below such cut-offs rise with age for both families (as measured by age of head) and unattached individuals, especially among those living alone or in households without relatives.

Studies show that older census families*** appear to have lost ground in the seventies compared to middle-aged census families in terms of incomes and their ability to keep up with inflation.

The contribution of indexed government transfer payments to the incomes of the aging is very large, and it is this contribution that, on the whole, is crucial to the ability of the aged to keep up with inflation. The quarterly escalation of Old Age Security (OAS), Guaranteed Income

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* Stone, Leroy O., and Fletcher, Susan, A Profile of Canada's Older Population, Institute for Research on Public Policy/L'Institut de recherches politiques, Montreal, 1980.

** 1981 levels for a single person and a couple are given in the part of this section entitled "Comparison of OAS/GIS and OAS/GIS/SPA Maximum Benefit Levels to Low-Income Levels".

*** Census family, as defined by Statistics Canada, consists of a husband and wife (with or without children who have never married, regardless of age) or a lone parent, regardless of marital status with one or more children (who have never married, regardless of age) living in the same dwelling. Persons living common law are reported as married.

Table 3

Source of Income Among Those 66 and Over, by Low-Income Class and All Income, 1979

Source	Single Males*		Single Females*		Couples**	
	Under $3,500	All Income	Under $3,500	All Income	$4,000 -5,999	All Income
OAS/GIS/SPA	87.0	35.7	86.6	48.2	88.2	40.2
CPP/RRQ	3.7	8.5	2.8	7.7	4.9	8.5
Social Assistance/ Provincial Supplements	1.0	1.0	2.1	2.1	2.4	1.5
Other***	0.2	0.7	0.3	1.0	-	1.1
All Public Sector	91.9	45.8	91.9	59.0	95.5	51.4
Investment Income	6.8	28.3	5.0	23.2	4.1	25.7
Retirement Pensions****	0.8	14.6	2.2	12.7	0.1	14.0
Earnings	0.4	11.2	0.9	5.0	0.2	8.9
All Private Sector	8.1	54.1	8.1	41.0	4.5	48.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Survey of Consumer Finances public use microdata file.

* Single Males/Females: All of the aging not living in families, though may include some living with relatives other than parent-unmarried children relationships.

** Couples include those only where both partners were 66 or over.

*** Veterans' Pensions, Workmen's Compensation, etc.

**** Income from employer-sponsored plans, superannuation, and annuity income.

Note: Unlike previous years, the 1980 SCF, which collected the 1979 data, included in its sample a small number of persons with income over $100,000. This plus higher imputed income figures for the 1980 SCF (because of lower response than previous years), makes these figures not comparable with those for previous years published in other reports.

Supplement (GIS) and Spouse's Allowance (SPA) payments to the full increase in the Consumer Price Index (CPI) increase since 1973 has generally meant that government transfer payments have become the major source of income of the aging at increasingly higher income levels, and this is particularly the case among very old Canadians.

One of the reasons why OAS, GIS and SPA have been an important income source in the past is their indexing. Those aged persons who have private sector pensions generally do not have indexed pensions, although it should be noted here that over three quarters of larger plans have made adjustments to retirees' pension benefits in times of inflation. Furthermore, the transfer payments are growing in importance among the aging largely because employment to supplement income falls sharply in the age 70 and over population relative to 65-69 year olds, as well as because of the fact that the bulk of the recently retired have some investment income which has normally been converted to cash in later retirement years. A major reason as well is the disproportionate number of women who receive few survivor's benefits when their husbands die.

While private pensions have not been a major source of income among the aging - indeed, the contribution of government transfer payments to the aging was three to four times higher than all private pension payments in the mid-seventies - the role of private pensions increased during the seventies. Simple trends suggest that close to 15 per cent of the incomes of the aging in 1980 will come from this source and perhaps up to a fifth of income in 1990.* This contrasts with about 11 per cent at the start of the 1970s. All the same, males have been the principal beneficiaries of this rising share from private pensions and, for some time to come, can be expected to remain the prime beneficiaries.

Another part of the growing importance of transfer payments among the unattached aging is the fact that most of the unattached aging are women. In the late seventies, about seven in 10 of the unattached aging population were women, and about 85 per cent of these were widows. Indeed, since 1975, about 60 per cent of the income to older women has been from transfer payments. In large part, the relative inadequacy of the incomes of unattached individuals - as measured by Statistics Canada Low-Income Cut-Offs - is because the older female population has had few earnings contributions to either public or private pension plans.

The income inadequacy of the unattached aging population is severe by any standard. Couples, by pooling their income and the sharing and exchange of help and services, can enhance their living standards and enjoy economies of scale. Studies have shown that the cost of living of unattached individuals is about two thirds that of a couple, while their income averages to under half that of couples. It must be recalled that between

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* Grouping the Canada Pension Plan (CPP) and Régime de Rentes du Québec (RRQ) with private pensions accounts for 20.4 to 23.1 per cent of income, depending on marital status, in 1979.

70 to 80 per cent of unattached women do not live with relatives. Table 4 shows the income distribution of unattached men and women in 1979. It should be noted that proportionately more of the more numerous female population is found at incomes below $4,000 than is the case for the smaller male population. Other data from the SCF show that while 33 per cent of single men had incomes below Statistics Canada Low-Income Cut-Offs, some 42 per cent of single women had incomes below these cut-offs.

Table 4

Per Cent Distribution of Unattached Persons Aged 66 and Over, by Income and Sex, 1979

Income Group	Male	Female
Under $2,000	3.0	2.3
2,000-2,499	5.3	4.9
2,500-2,999	3.1	3.3
3,000-3,999	18.5	25.6
4,000-4,999	24.6	27.9
5,000-7,499	18.6	18.5
7,500+	26.9	17.4
Total	100.0	100.0

Source: Survey of Consumer Finances public use microdata tapes (1979) for census families; excludes unattached individuals living in families and the population resident in institutions for the aged.

Another measure that has been used to test the income adequacy of the aging population is the savings-to-income ratio. If the population of aging Canadians is grouped into three income groups, the two lower groups are characterized by dissaving or very minor positive changes in assets and liabilities. Only the third highest income group shows significant amounts of saving.* It is also this group that shows significant expenditures on travel, domestic help, cleaning and personal care services.

Objections can be lodged against the view of income as adequate or inadequate as measured by either low-income cut-offs or savings-to-income ratios. Certainly, non-income transfers are very important to the measure of adequacy. For instance, in 1976, close to one fifth of spending units aged 65 and over (as indicated by age of head of a unit of one or more individuals) reported reduced rent arising from government subsidies. As well, the low-income cut-off approach, being solely an income measure, cannot take into account special tax exemptions for the aging nor the differences in the tax treatment of pension and investment income (favouring the aging), nor, for that matter, the existence of provincial and federal expenditure subsidies for a variety of goods and services. All the same, however, the two measures together appear to give a picture of comparative disadvantage of the aging compared to younger population age groups, and, within the aging, "single" women are relatively worse off than all others.

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* The logic of using savings-to-income ratios or "dissaving" to measure the adequacy of older people's incomes is not without objections, foremost among which is the question "why do people save if not to dissave at a later point in time?". Drawing pensions or annuities is a form of "dissaving", for example. If saving has occurred in early life, requirements for saving in later life are probably low.

Still, it can be said that the aged at all income levels proportionately own more homes without any mortgage obligations than do Canadians in general, and that this proportion is remarkably stable across all income levels, from low to high. Until, however, the relative costs of such home ownership among the aged are better understood and measured - in terms of maintenance and heating, for example - it may be hazardous to impute an income benefit to such ownership. Data show that proportionately higher amounts of income are spent by the aging on shelter. While data sources which point to the magnitude of shelter expenditures among the aged identify a much higher incidence of shelter affordability problems among renters, about 30 per cent of elderly owners spent from 25 per cent to over 35 per cent of their incomes on shelter in 1978. Rising energy costs since that time have probably raised this proportion.

Lastly, there is no evidence that the aging who own homes are able to convert this asset into a stream of wealth. There are few reverse annuity mortgages and other such mechanisms to convert assets into income in Canada, and, since annuities are income, conversion could involve the full-to-partial loss of income supplementation benefits in money and in kind. As well, because such annuities are taxed like any other annuity, as income, there is some question about the net after-tax position of those choosing to use this instrument. These factors partly explain why the conversion of a home asset into income has not developed significantly in Canada.

THE CURRENT SITUATION

The bulk of Canada's programs affecting the income security of the aged are age-specific in the sense that they apply either to the entire population of the aged or to a specific group within the aging population (such as, for example, those just leaving the labour force at age 65 or over). Consequently, universal programs that benefit all age groups are of generally minor importance in directly providing income to the aged, although they are of more major importance in providing goods or services at below market prices or at no cost.

Universal Programs

(i) Health Insurance

The implementation of the Hospital Insurance and Diagnostic Services and Medical Care programs has meant that most Canadians receive medical attention and services at little to no direct personal cost. The majority of the provinces finance their share of health insurance plans from general revenue; in the remaining provinces, the 65 and older population is exempt from paying the premiums which represent a major source in funding these plans. Since the introduction of these plans in Canada, personal expenditure on medical and hospital care, particularly among the older unattached aging population, has fallen substantially. For the aging in general, the implementation of these plans has increased the discretionary component of their income, as well as ensured that savings for retirement would not be consumed in medical and hospital bills if they had health problems. The health insurance system is generally supplemented by a variety of drug and other assistance plans for the aging, which are described in the health section.

(ii) Unemployment Insurance (UI)

Workers up to their 65th birthday are entitled to regular unemployment benefits and to sickness and maternity benefits, provided they have made the necessary contributions.

Since 1975, an annually-adjusted three-weeks lump sum retirement benefit has existed for UI contributors who, at the age of 65, when UI contributions must cease, have at least 20 weeks of insurable employment.

(iii) War Veterans

A Veteran's Pension is payable in respect to death or disability attributable to military service. The amount of pension varies, depending upon previous rank, extent of disability, and the number of dependants. It is not affected by other income and is not taxable. It is adjusted for increases in the cost of living. The Compensation for Former Prisoners of War Act provides compensation to former prisoners of war and their dependants.

War Veteran's Allowances (WVA) are an income-tested benefit payable to needy veterans and to certain civilians with overseas service as Civilian War Allowances (CWA), or to their survivors, provided that the annual income is less than $1,000 if single and $1,500 if married. Any income above the exempted level, including OAS payments, results in an equivalent reduction in the allowance. The purpose of the program is to provide income support to veterans who, because of age or incapacity, are unable to work and have insufficient income for maintenance as determined by a modified income test. About 95,000 veterans, widows, orphans and eligible civilians in total were covered under WVA/CWA. WVA/CWA recipients whose incomes are less than the maximum specified in the legislation are eligible for additional assistance from the Assistance Fund, which may either be a single payment or a monthly supplement. On March 31, 1980, 23,932 WVA/CWA recipients received monthly assistance fund payments.

(iv) Special Industry and Labour Adjustment Program

Pre-retirement benefits, payable only where lay-offs are certified as having been a consequence of the government's policy, provide a basic level of income to older workers from the time their unemployment insurance benefits expire until they reach age 65. To be eligible, workers must be certified by the appropriate industrial board, be between 54 and 64 years of age at the date of lay-off, have had at least 10 years' employment in the industry within the 15 years immediately preceding lay-off, and have been paid by a Canadian producer for at least 1,000 hours in each of those 10 years. Each qualified worker must be further certified by Employment and Immigration Canada as a person resident in Canada having no present prospect of employment with or without further training or relocation assistance, or as having accepted employment with earnings that are less than his/her average weekly insurable earnings immediately before lay-off.

The maximum pre-retirement benefit is equal to the maximum UI benefit or earnings in a full working week as determined under a work-sharing agreement. The maximum benefit is reduced at the rate of 66 2/3 cents for each one dollar of earnings and/or pension income. Benefits are subject to annual adjustment based on changes in the earnings index as set out in the Unemployment Insurance Act.

This program is also discussed in other respects in the section on labour and employment.

(v) Minimum Wage Legislation

The federal government under the Canada Labour Code, 1966 and all provinces under their legislation set minimum wages from time to time. Workers, including those age 60 and over, are protected through this legislation from being forced to accept very low wages.

(vi) Registered Retirement Savings Plans (RRSP) and Annuity Plans

To encourage individuals to save for retirement, the Income Tax Act offers incentives by providing for the exemption from tax of contributions to Registered Retirement Savings Plans (RRSP) on behalf of the contributor and/or the contributor's spouse and for the exemption of the interest earned on these funds. The annual limit for a person not contributing to an employer-sponsored plan is the lesser of $5,500 or 20 per cent of earned income. Members of employer-sponsored plans can contribute to an RRSP for himself/herself or on behalf of his/her spouse, providing the combined total does not exceed the lesser of $3,500 or 20 per cent of earned income. Withdrawals from the fund may be made at any time by de-registering the plan. When this is done, these funds are considered as income in the year they are received. After age 60, the funds may be used to purchase a life annuity or fixed-term annuity to age 90, in which case only the income received in a given year is taxable. A contributor has until age 71 to de-register or purchase a life annuity; otherwise the full amount of the assets remaining in the fund becomes taxable.

An RRSP can be converted into a regular retirement income through a Registered Retirement Income Fund. Under this arrangement, a stream of income will be paid assuming that the capital will earn a selected rate of interest not exceeding six per cent per annum. To the extent that the capital earns more than this selected rate, the additional earnings will be used to increase future payments. Similarly, RRSP proceeds can be used to purchase annuities under which payments increase to reflect the earnings on a specified group of assets.

The federal government has operated a residual program of government annuities established under the Government Annuities Act, 1908. Some of the aging today receive annuities under this program; some will become eligible for them in future.

(vii) Tax Treatment of Private Savings

Private savings, over and above contributions to employer-sponsored pensions and RRSPs, are subject to an exemption from income taxation of the first $1,000 per year of dividend and interest income from Canadian sources. Such private savings play an important role in providing for retirement needs.

While it has been the case that any portion of an individual's $1,000 deduction for pension and investment income, if unused, could be claimed by that person's spouse, proposed new tax provisions do not allow this transferable deduction to exceed the amount by which the marital exemption of the supporting taxpayer is reduced. For example, if an individual with no other income received less than $550 from pensions and interest, the marital exemption of the other would not be affected, so no deduction would be transferable.

The federal dividend tax credit in respect to dividends from taxable Canadian corporations is used to reduce taxable income. These credits are another tax measure that assists the aged.

(viii) Provincial Tax Credits, Rebates and Rental Assistance

Certain provinces offer tax credits or rebates of taxes which improve the income position of low-income elderly persons. In some cases, the credits or rebates apply only to elderly persons (being therefore targeted) and in other cases they apply to the total population. Because the general features of these plans, targeted or not, are similar, they have been grouped together for discussion purposes.

An annual Pioneer Utility Grant of $360 is available to senior citizens age 65 and over, or surviving spouses age 60 and over in the Yukon Territory. The eligible senior must reside 183 days annually in his/her home, 90 days during the winter months. The senior must be living in non-subsidized housing.

British Columbia provides property tax relief for homeowners 65 years and over, a senior homeowners grant for those 65 years and over, and gives elderly persons the opportunity to defer taxes until the property is sold.

Alberta provides property tax rebates for elderly persons 65 years and over and to widows and widowers aged 60-64 if the deceased spouse was age 65 or over at death.

Saskatchewan provides school tax rebates and property tax rebates to elderly persons, a senior citizens' tax credit of $50 for those 65 years and older, and a capital gains tax rebate for farmers and small businessmen which is largely used by those age 50 and over.

Manitoba provides a property tax credit for all property owners and renters, the amount depending on income; a special rebate to elderly homeowners in respect to imputed school taxes, and a rebate of the school tax component of rentals to elderly home-renters; a cost of living tax credit under income taxes imposed by Manitoba; and opportunities for the deferral of property taxes until the residence ceases to be occupied by the elderly person.

Ontario provides a pensioner tax credit under the income tax system to every person living in Ontario age 65 and over and to married couples one of whom is age 65. Property tax grants, sales tax grants, and heating grants for a temporary period are available to the same 65 and over age group. For taxpayers up to age 65, property and sales tax credits are provided through the income tax system; the amount of which depends on the taxpayer's income.

In Quebec, the Department of Revenue administers a program under which all persons with lower incomes, owners and renters, are eligible for a property tax rebate; for which many elderly persons are eligible. This program replaces a former program administered by the Quebec Pension Board.

In some cases, property tax relief is established on a local basis. For example, the City of Toronto provides a $100 tax credit to those in receipt of the federal GIS who have resided at least five years in owner-occupied homes. A recent survey shows that, in the Province of Nova Scotia, most municipalities provide direct tax relief to senior citizens with low incomes. The amount of the tax relief is not, however, uniform.

In addition to tax rebates and tax credits, some provinces offer shelter and rental assistance. British Columbia provides assistance through the Shelter Aid for Elderly Renters program. Alberta provides annual grants of $1,000 to renters age 65 and over, $500 for those in subsidized accommodation, and $600 for elderly owners of mobile homes. Manitoba provides assistance through the Shelter Allowances for Elderly Renters program. New Brunswick and Nova Scotia make direct payments to elderly renters.

Targeted Programs

Income security targeted to the aging in Canada is provided through a number of programs. These are federal and provincial pension and income support programs, tax benefits provided under federal and provincial programs, and arrangements in the private sector, such as employer-sponsored pension plans.

(i) Old Age Security Program (OAS)

The OAS Program pays a flat rate pension to all persons in Canada aged 65 and over who meet residence requirements and are Canadian citizens or legal residents as determined under the Act. The pension may either be full or partial, depending on the length of residence in Canada. There are two methods of meeting residence requirements for full pensions. Persons who were 25 years of age or over on July 1, 1977 and resident in Canada on that date, or those outside of Canada on that date with some prior residence in Canada after age 18 and who meet other residence requirements under the Act may qualify for full pensions at age 65. Persons who were not yet 25 or not yet resident in Canada at that date, will qualify for full pensions only if they reside in Canada for 40 years after reaching age 18. Those who cannot qualify for a full pension may receive a partial pension calculated at 1/40th of the full pension for each complete year of residence in Canada after reaching age 18, provided they have at least 10 years' residence. The OAS pension, GIS and SPA are all adjusted each quarter for increases in the cost of living, as measured by changes in the CPI. The OAS pension may be paid to residents of other countries and outside of Canada if the pensioner has resided in Canada for at least 20 years after reaching age 18. Otherwise, it may be paid for six months following the month of departure from Canada, to be resumed when the pensioner returns to Canada.

In April 1982, the amount of the OAS pension was $232.97 per month, with 2,368,569 pensioners having received the pension in March 1982. Slightly less than one per cent of this number received partial OAS pensions.

(ii) Guaranteed Income Supplement (GIS)

The GIS may be maximum or partial, depending on incomes measured by an annual incomes test. The supplement is paid to OAS pensioners with little or no other income. Entitlement is normally based on the pensioner's income in the year preceding the benefit year. Income is net income excluding income from OAS/GIS/SPA, and provincial supplements for the aged, and net of the same deductions allowable in computing net income for income tax purposes. An important point is that benefits are reduced by $1 for every $2 of other income. The amount of the supplement is paid in Canada but can be payable for six months outside of Canada following the month of departure. Payment may be resumed when the pensioner returns to Canada if the other conditions of eligibility are met. Where a pensioner has ceased to reside in Canada, payment may only be resumed when he or she again takes up residence in Canada.

The monthly amount of GIS was $233.89 as of April 1, 1982 for a single pensioner and $180.32 for each married pensioner. In March 1982, 1,256,813 or 53.1 per cent of OAS pensioners also received GIS with about 27 per cent receiving maximum benefits and 73 per cent partial amounts.

(iii) Spouse's Allowance (SPA)

The SPA is either a full or partial amount. It may be paid to the spouse of an OAS pensioner, if that spouse is age 60 and over but under 65, and meets the OAS residence and low income requirements. The amount payable is determined by an income test that takes into account the couple's annual net income computed in the same way as for GIS. Eligibility for SPA is contingent upon the OAS pensioner spouse being eligible for GIS, except if the pensioner spouse should die, in which case SPA eligibility may continue. The SPA is paid in Canada, but may also be paid to recipients outside Canada for six consecutive months following the month of departure. Payments may be resumed when the SPA recipient returns to Canada if the other conditions of eligibility are met. Formerly, the SPA was terminated when the pensioner spouse died. An amendment to the OAS Act, effective November 20, 1978, provided for an extension of the payment up to six months after the death of a pensioner's spouse. A further amendment, effective November 1979, provided continued eligibility to age 65 or remarriage. The monthly amount of the SPA was $413.29, effective April 1, 1982. In March 1982, there were 87,103 spouses receiving the allowance. A key to the calculation of the SPA monthly rate is that it is equivalent to the full OAS pension plus GIS at the rate for each married pensioner.

(iv) Comparison of OAS/GIS and OAS/GIS/SPA Maximum Benefit Levels to Low-Income Levels

Basic income support is provided under the OAS program to persons age 65 and over through a combination of OAS and GIS and to families where one spouse is in the age group 60-64 and the other aged 65 and over through a combination of OAS/GIS and SPA. Basic amounts of income support are often compared to certain low-income standards. One low-income standard which has been in effect for a long time and against which comparisons are often made, is the low-income cut-offs developed by Statistics Canada. A comparison is set out below for 1981 between OAS/GIS/SPA levels and the Statistics Canada low-income measures.

	1981 Statistics Canada Low-Income Levels	1981 OAS/GIS, OAS/GIS/SPA
	$	$
Single person	5,957	5,092
Couple	8,638	9,015

(v) Provincial Supplements for the Aging

Six provinces (Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia) and the Northwest Territories have programs which supplement the benefits paid under the federal OAS program. As eligibility is usually tied to eligibility for GIS, recipients in most provinces must be age 65 to qualify. British Columbia, however, provides benefits commencing at age 60. Benefits are generally subject to an income test. The reduction of provincial benefits for those with additional income varies from program to program. The existence of these programs increases the amount of retirement income for persons with little income from private sources, public sources including OAS/GIS, and/or CPP/RRQ. In most cases, benefits are reduced by $1 for every $2 of other income. With GIS, this results in an effective tax-back rate of 100 per cent.

(vi) The Canada Pension Plan (CPP) and Le Régime de Rentes du Québec (RRQ)

(a) Canada Pension Plan (CPP)

The CPP is an integral part of Canada's social security system. Under the plan, which commenced in 1966, millions of members of the labour force acquire and retain, during their productive years, protection for themselves and their families against loss of income due to retirement, disability or death, regardless of where they are employed in Canada, and in certain circumstances outside Canada. Employees contribute at the rate of 1.8 per cent of their earnings falling between the minimum and maximum established each year. The maximum level in 1982 is $16,500, and the minimum is $1,600. Employers pay a matching contribution and self-employed persons pay 3.6 per cent on earnings falling in this same range of earnings. The plan is designed to provide a maximum retirement pension equivalent to 25 per cent of the average adjusted pensionable earnings.

The plan pays retirement pensions to contributors age 65 and over; disability pensions to disabled contributors under the age of 65 as well as benefits to the children of a disability pensioner who are under age 18, or under age 25 if a student; pensions to the surviving spouse (male or female) of a deceased contributor and orphan's benefits to any surviving children under age 18, or under age 25 if a student; and a lump sum death benefit to the estate of a deceased contributor. At age 65, a disability pension is converted to a retirement pension and the benefit paid to the child of a disability pensioner is terminated. At age 65, a different formula is applied to determine the amount of the survivor's pension (i.e., 60 per cent of the deceased contributor's retirement pension). CPP benefits are adjusted each year for changes in the cost of living as measured by the CPI, and are payable anywhere in the world.

A provision under CPP, effective January 1, 1978, that has implications for the family provides for the division, on marriage dissolution, of pension credits earned by one or both spouses during the years of marriage. The provision applies only to couples divorced since 1978. These credits may be divided equally between the spouses following a divorce or legal annulment of the marriage. The spouses must have cohabited for at least three consecutive years during the marriage and application must be made within three years of marriage dissolution. A spouse with no or lesser pension credits would, under this arrangement, become entitled to credits or higher credits. The major beneficiaries under this arrangement are the older divorced women who have spent a large part of their lives working in the home, but not as paid members of the labour force. Since, as well, women's wages are generally lower than men's, women who have worked stand to benefit more than men.

CPP is administered by the Department of National Health and Welfare through a network of 150 local and district offices. The Department of National Revenue is responsible for coverage and contributions. In February 1982, $232 million were paid in CPP benefits and some 1.4 million persons received benefits with about 895,000 receiving retirement pensions.

(b) Le Régime de rentes du Québec (RRQ)

Quebec exercised its constitutional right to establish a comparable provincial pension plan called the RRQ which operates in that province. The two plans, CPP and RRQ, are essentially similar but with some differences. RRQ provides higher benefits to survivors under the age of 65 and to disability pensioners, and pays a lower and fixed non-indexed flat rate amount for orphans and children of disability pensioners. With the exception of the childrens' benefits, all other benefits are indexed each year to reflect increases in the level of consumer prices in Canada. RRQ makes provision, effective January 1, 1977 for the division of pension credits on marriage dissolution as is done under CPP. In addition, RRQ has since 1977 provided a further measure of financial help to spouses who work in the home. Contributors who stop working to raise children can drop from their contributory periods the periods of low or zero earnings during which their child is being raised until the child reaches age seven. Because of the shortened contributory period, this latter arrangement increases average pensionable earnings and hence the amount of benefits payable.

In February 1982, $79 million in benefits were paid under RRQ to 438,216 beneficiaries, 258,525 of whom received retirement pensions. In fiscal 1980-81, about $705 million were paid out to all beneficiaries under RRQ.

(c) Comparison of benefits

The following are the maximum monthly benefits paid under CPP and RRQ for 1981.

Benefit	CPP	RRQ
	$	$
Retirement	274.31	274.31
Disability	268.64	367.04
Survivors		
- 65 and over	164.59	164.59
- under 65	165.78	264.18
Children and Orphans	62.91	29.00
Death (lump sum)	1,470.00	1,470.00

(vii) International Social Security Agreements

The Government of Canada has negotiated reciprocal international agreements with the United States of America, Italy, France, Greece and Portugal covering the OAS program and the CPP. The agreements with the U.S.A. and Greece are not yet in force. The same situation holds with respect to the understandings which Quebec has negotiated with these same countries for programs falling under its jurisdiction, in accordance with the provisions of the above agreements. The agreements and understandings deal with matters such as coverage and social insurance credits established through contributions and/or residence, and provide for the combination of periods and/or credit entitlements acquired in both countries to establish eligibility for social security benefits in Canada or in the other country or both. Through these agreements and understandings, a person coming to Canada who has been covered by the social security plan of another country may be able to put both sets of credits together (Canada and the other country) and establish entitlement to benefits from Canada and/or the other country to which he/she would not otherwise be entitled. The Government of Canada has also entered into an exchange of letters with the United Kingdom on social security matters and a Convention on Social Security with the Federal Republic of Germany which are more limited in scope than the reciprocal agreements.

(viii) Social Assistance

Elderly persons in Canada may be entitled to income support from a number of public programs such as: OAS, GIS, SPA, CPP, RRQ, and depending on the province from provincial supplements for aged persons. For those elderly persons who are not eligible for these programs, or who are eligible, but whose incomes in either case are not adequate to meet their needs, additional income support may be provided. This income support is available through provincial and/or municipal social assistance or social allowance programs. The cost of this additional income support is shared with the federal government under the Canada Assistance Plan (CAP) as outlined in the section on social welfare.

(ix) Private Pension Plans .

Provincial jurisdiction over employer-sponsored pensions is primary in Canada. The Income Tax Act since 1919 has encouraged saving for retirement through employer-sponsored pension plans which include the pension plans of government employees and the employees of private business. The Act, currently under review, has rules limiting the amount of tax deductible contributions which employers and employees can make to registered pension plans. Investment earnings of registered pension plan funds are tax exempt. When paid out as an annuity, the first $1,000 is tax exempt. Nova Scotia, Quebec, Ontario, Manitoba, Saskatchewan and Alberta have legislation regarding pension benefits' standards. The federal government has similar legislation applicable to employees whose employment comes under federal jurisdiction. Pension legislation in all these jurisdictions deals with such matters as vesting, solvency of pension plans, regulation of pension fund investments, and the provision of information to covered employees. About 4.2 million persons were enrolled in employer-sponsored plans in 1978 - or 44.1 per cent of the paid workers in the labour force. Some of the larger plans provide bridging benefits, usually equivalent to the CPP/RRQ retirement pension, from the date of retirement to age 65. This arrangement permits a person to retire early without undue loss of income. Less than half of these plans provide for the payment of some form of survivors' benefits if the member dies before retirement, and even fewer provide for an on-going pension income. Payment of widows' pensions is most common among the larger plans, particularly in the public sector.

The only comprehensive data currently available on the numbers of pensioners and benefits paid are the published and unpublished data from Revenue Canada Taxation statistical records. These data have limitations because they do not distinguish among types of pensions and do not, of course, include data on low-income pensioners who are not obliged to file tax returns. Bearing these data limitations in mind, in the 1976 taxation year a total of $2.1 billion in pension benefits were paid to 725,245 beneficiaries, an average of $2,885. Male beneficiaries reported an annual average of $3,331 and females $2,122.

(x) Benefits and Exemptions Under the Income Tax System

A person aged 65 or over is entitled under the Income Tax Act to an age exemption ($1,980 in 1981) in addition to the basic personal exemption available to all persons ($3,710 in 1981). In addition, exemptions of $1,000 are provided for interest, dividends and capital gains, and $1,000 for pension income, as well as a standard deduction of $100 for charitable donations. Deductions are also provided for blind persons or persons confined to a bed or wheelchair ($1,980 in 1981). The Income Tax Act provides for the transfer of the unused part of the eligible deductions (but not the standard deduction) from one spouse to the other where one spouse has little or no taxable income but the other spouse does. The Province of Quebec under its income tax legislation also provides the age exemption, the net interest and dividend, and pension income deductions, the disability exemption and the standard deduction, and as well has arrangements to transfer these deductions and exemptions (except the standard deduction) between spouses. Deductions are also provided under both the federal and Quebec tax systems for contributions to CPP/RRQ, UI, registered pension plans, RRSPs and Registered Home Ownership Plans, alimony or separation allowances, medical expenses, charitable donations, employment expenses, child care expenses, and other deductions. All of these exemptions and deductions reduce the amount of taxes to be paid and increase the disposable incomes of all taxpayers, including the aged.

A PERSPECTIVE ON THE ISSUES SURROUNDING INCOME SECURITY

It is evident that governments play a key role in determining the income of the aging in Canada through direct income transfers such as OAS/GIS/SPA and provincial income supplements, through establishment of the earnings-related public pension plans, and through regulation of private pension plans. These initiatives have succeeded in providing a high degree of income security for the aging. Further improvements will occur as recent developments such as the maturing of the CPP/RRQ, the more widespread use of RRSPs, and greater pension coverage generate increasing flows of income to the aged in the future.

Nevertheless, a number of problems have been identified within the guaranteed income system, and governments have indicated their commitment to alleviate these problems. In this connection, the National Pensions Conference was convened in 1981 to discuss problem areas. At the conference two basic goals of Canada's mixed system of public and private pensions were articulated. These goals are: (i) the alleviation of poverty among the aged, and (ii) the maintenance of living standards in retirement that are roughly equivalent to those enjoyed in working years. Discussions focussed on four major issues: (i) coverage; (ii) portability, vesting and locking-in; (iii) protection against inflation; and (iv) women and pensions. These four headings comprise a useful focus for discussion of the issues.

Coverage

While virtually all workers have pension coverage under the CPP and RRQ, half the work force does not belong to an employer-sponsored pension plan. The most notable gaps in coverage occur in the private sector. According to the study Pension Plan Coverage in Canada,* the groups with the largest number of people who had no pension plan coverage in 1979 were females in the private sector who earned less than the average wage of $15,000 and males in the private sector earning up to 1.5 times this average wage. There were more than two million women working in the private sector who earned less than the average wage and had no private pension protection. Similarly, some 1.6 million men earning less than the average wage worked in the private sector and had no pension protection. Another 500,000 men who earned between the average wage and 1.5 times the average wage in the private sector had no pension protection. This is one view of coverage. Many people are of the view that coverage is much broader when RRSPs, Deferred Profit Sharing Plans, Guaranteed Investment Certificates, equities, real estate, etc. are taken into account.

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* Income Security Programs Branch, Pension Plan Coverage in Canada, 1978-1979, Department of National Health and Welfare, Ottawa, 1981.

The major issue for Canada is whether governments wish to encourage the voluntary expansion of pension protection, or whether they wish to increase the guarantee now provided to all Canadian workers by either expanding the CPP/RRQ they have access to, or making private pension protection compulsory or some combination of the two. Among measures being discussed for encouraging an adequate retirement income are measures to encourage savings, improved federal/provincial benefits' legislation, improved tax incentives towards establishing employer-sponsored plans, and the creation of new plans for small businesses. It should be noted, however, that most of those older Canadians in the lower income range receive full replacement income or close to it from existing income transfer plans.

Possible compulsory measures include the introduction of mandatory minimum private plans and/or expansion of the CPP/RRQ in terms of benefit levels. To effect changes to CPP, the consent of two thirds of the provinces with two thirds of Canada's population is required.

National Pension Conference participants failed to reach a consensus on the coverage issue.

Vesting, Portability, and Locking-In

Despite the fact that a large number of Canadians belong to a pension plan at any given time, a fair proportion will not draw substantial pensions on retirement. This is a result of the fact that the average Canadian worker can be expected to change jobs (employers) up to six times on average during his or her work life. Many lose their pension credits in such moves because of a lack of portability or of early vesting. As pensions increasingly are seen as deferred wages, the vesting and portability of pension credits among workers who change employers several times in the course of their working life is of great concern.

Earlier vesting and locking-in were seen as desirable reforms for private pensions by the National Pensions Conference. There was a strong consensus in favour of improved vesting provisions. The objective was to move progressively towards full and immediate vesting over a relatively short period of time, with perhaps an initial move to five years or less of service as a requirement.

There is virtually unanimous agreement that the rights of persons to receive benefits under private plans to which they have contributed should be strengthened. Again, on the measures to strengthen plans, there is considerable debate.

Protection Against Inflation

Inflation has a serious effect on the real value of pensions and annuities. In 1978, only about 214 plans covering 30 per cent of the members of all private plans provided for automatic escalation of benefits. These were largely in the public sector. If pensions and annuities are not indexed to compensate for rising prices, and the level of inflation of the 1970s continues into the future, pension benefits will be seriously eroded and the system of employer-sponsored pensions and tax-induced RRSPs may be called into question.

There is an emerging consensus that corrective action must be taken. The inflation of the past decade has been a particular problem to the aging and has increased dependency on government income transfers. Measures to provide a greater degree of inflation protection of private pension benefits have been studied extensively and, along with other issues are at the heart of the current debate about reform.

Women and Pensions

Occupation, employment and income barriers facing women in the work force result in lower pensions receivable when they reach pensionable age. While federal and provincial governments have done much to eliminate discrimination, more appears to be needed.

There are four general thrusts to discussions surrounding women and pensions. These are: (i) improving the benefits under OAS/GIS to ensure that the majority of Canada's elderly unattached women (and men) have incomes above a poverty level (i.e., low-income cut-offs); (ii) improving survivors' benefits; (iii) extending coverage for part-time workers; and (iv) extending pension protection to homemakers* in their own right, with provision for those who leave the labour force to take care of dependent family members and provision for those who, because of family responsibilities, have never been members of the paid work force. The issue of splitting private pension credits, as in the CPP/RRQ, has been widely discussed in this context.

There is virtually unanimous agreement on the first issue and mechanisms to accomplish it are currently being explored.

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* Homemaker used in connection with pensions means a spouse, not attached to the labour force, but whose work is caring for home and children. It does not apply to a "homemaker" who provides a social service through a program, e.g., home care program.

On the second issue, survivors' benefits, the perception that pension credits should be seen as joint assets of a married couple has generated pressure for improved survivors' benefits. In 1980, the study Pension Plans in Canada* shows that about 78 per cent of members of private employer-sponsored pension plans, and about 30 per cent of members of public sector plans, had no provisions for survivors' pensions if the contributing spouse died after retirement.

At the National Pensions Conference almost everyone favoured mandatory survivors' benefits in public and private plans.

Trends in the labour market suggest that part-time work is increasing in importance for both men and women, but especially women. The ability of part-time workers to participate in pension plans is an issue.

Homemakers in Canada have no access to pensions in their own right other than the OAS pension. Opinion on extending coverage to them under the auspices of CPP/RRQ is divided. For example, there is a view that survivors' benefits would correct the problems of coverage for them, but another view that the homemaker should not necessarily be dependent on a spouse's success or failure in the work force for an entitlement. There is agreement on the opinion that opening CPP/RRQ to voluntary contributions would be difficult from an administrative perspective. But, however much opinion is divided, debate and discussion on this point are current in Canada. It may be noted that in 1977 the Parliament of Canada approved the same drop-out provision as in the RRQ referred to earlier, but this has yet to receive the approval of two thirds of the provinces with two thirds of the population.

Finally, while having presented the major issues of coverage, portability and vesting, inflation protection, and women and pensions - all of which are central to current discussion - it should be noted that measures to improve employment-related pension schemes will have little impact on the population currently in, or near retirement. For these groups, policy discussions focus on the adequacy of income transfer programs or on modifications to the public programs.

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* Pension Plans in Canada 1980, Statistics Canada Catalogue 74-401, Ottawa, March 1982.

LABOUR/EMPLOYMENT

THE LABOUR/EMPLOYMENT EXPERIENCE OF THE AGING

Every eighth Canadian in the population aged 15 and over, from which the labour force is drawn, is 65 or more, but this older age group accounts for less than one in 50 Canadian workers. A fair portion of the aging can and do choose lifestyles that allow them to meet their aspirations outside of paid work. On the other hand, background studies for the Task Force on Labour Market Development show that others have been kept out, or forced out, of the labour market before their chosen time. Decisions are made on the basis of a plurality of interests in which, all too often, the older worker has had little say.

Although no clear trend indicating future participation in paid work has emerged, the long-observed decline in the attachment of aging men to the work force is expected to continue. Declining participation rates among men over age 55 may be due to an increased incidence of early retirement. As for older women, whose participation has resembled a wave with its crest in the early seventies, arguments for and against another wave abound. Recent evidence shows that among women there is increasing labour force attachment among all age groups. But the behaviour of the older woman is not the cause of uncertainty about the future. Rather, if people in future can retire when they desire; barriers against women and the aged in job markets are reduced; special policies and programs are developed surrounding selective placement; and affirmative action, retraining, and greater freedom of mobility come into effect, then the outcome is uncertain. Table 5 reflects the immediate past, and serves as a future trend indicator.

Table 5

Labour Force Participation by Age Group, 1981

		Change from 1976	
Age Groups 15 Years+	Participation Rate, 1981	Men	Women
All groups	64.7	+	+
15-19 years	55.7	+	+
20-24 years	79.7	+	+
25-34 years	80.4	−	+
35-44 years	80.3	+	+
45-54 years	74.2	+	+
55-64 years	53.4	−	+
65 and over	8.6	−	+
65-69 years	14.4	n.a.	n.a.
70+ years	5.2	n.a.	n.a.

*Source: Derived from The Labour Force, Statistics Canada Catalogue 71-001, 1976 and 1981. Annual Averages.

Table 6 shows that three quarters of those aged 70 and over who continue to participate in the labour force are found in service, trade and agriculture. Each of these industries is characterized by a substantial amount of self-employment and flexible work schedules. The high proportion in agriculture is because few farmers stop working due to age. Some two thirds of older men and women on Canada's farms work well beyond age 65; they form 21 per cent of Canada's workers 70 years of age and over.

When the occupational distribution is taken into account, as set forth in Table 7, it is significant that the proportion in professional,

Table 6

Per Cent Composition of Employment by Industry
Annual Averages, 1981
Canada

	Age Groups		
Industry	55-64 years	65-69 years	70+ years
All Industries	100.00	100.00	100.00
Agriculture	7.0	17.0	21.0
Non-Agriculture	93.0	83.0	79.0
Other Primary	3.0	*	*
Manufacturing	21.0	11.0	7.0
Construction	5.0	4.0	*
Trans., Comm. & Other Utilities	9.0	3.0	*
Trade	15.0	20.0	17.0
Finance, Insurance, Real Estate	5.0	8.0	8.0
Service	27.0	32.0	37.0
Public Administration	9.0	3.0	*

Note: All figures are rounded to the nearest per cent. The sum of the components may not correspond to the aggregate due to rounding.

* Estimates are too low to be reliable.

Source: Derived from Special Labour Force Tabulations, Labour Force Survey Division, Statistics Canada. Based on data collected in The Labour Force, Catalogue 71-001 for the 1981 calendar year.

Table 7

Per Cent Composition of Employment by Occupation
Annual Averages, 1981
Canada

Occupation	Age Groups 55-64 years	65-69 years	70+ years
All Occupations	100.00	100.00	100.00
Managerial, Professional	22.0	23.0	21.0
Clerical	14.0	10.0	10.0
Sales	11.0	15.0	17.0
Service	16.0	17.0	18.0
Primary	9.0	18.0	23.0
Processing	15.0	9.0	7.0
Construction	6.0	3.0	*
Transportation	4.0	*	*
Materials Handling & Other Crafts	4.0	*	*

* Estimates are too low to be reliable.
Source: the same as for Table 6.

technical, and managerial occupations remains over 20 per cent among aged workers and that primary occupations account for even higher proportions. Farm workers appear to constitute the bulk of primary workers (over nine in 10 in the age 70 and over population). The occupational evidence tends to support the inference drawn about self-employment. About four in five older workers are in categories where higher education has afforded them the opportunity to keep professional and managerial jobs, or perform as self-employed workers, or to pursue careers in self-employment, such as farming, sales, or service, where higher education may be deemed less necessary, although skill requirements may be significant.

No composite picture of the working aged emerges from participation or work patterns. This can be illustrated by considering women's labour market participation. On average, aging women have about one third the participation rate of men. Never-married women, however, have a slightly higher participation rate than men. There are other significant differences in the characteristics among women which add to the difficulty in constructing a useful composite. Table 8 serves to illustrate.

Motivation for working also differs. Some persons work to supplement income. Indeed, the highest work attachment of the older married population is in that group either without employer-sponsored pensions or not yet entitled to them. Even with work income, many such persons are poor by Canadian standards. While it is true that they might work if their incomes were better, on low incomes they have little choice about working and face enormous obstacles in getting work when they need it. Others work because they choose to; their education and aspirations give them access. Across all ages the better educated tend to participate more. The types of work the most highly educated perform often allow them to continue beyond age 65 in academic, managerial, professional or consultative capacities. In the later ages, perhaps because the less well-educated cannot get back on the job ladder when they lose their place, the differences in attachment are pronounced.

Table 8

Proportion of the Population Aged
65 and Over in the Labour Force
by Selected Characteristics, 1976

			Men	Women
All	12.3	Under Grade 5	11.3	4.0
Urban	10.4	Grades 5-8	17.8	5.3
Rural	18.7	Grades 9-10	21.1	7.3
Never Married	18.4	Grade 11	28.2	11.1
Married	15.2	Grades 12-13	25.0	9.3
Separated	12.5	Non-University Post Secondary	25.7	11.4
Divorced	16.0	Some University	28.7	14.6
Widowed	6.1	University Degree	37.1	20.3

Source: Census of Canada, 1976. The total records persons active in the census month; it is not comparable to the annual average figure for 1976.

THE CURRENT SITUATION - LEGISLATION, POLICY AND PROGRAMS

The bulk of Canada's legislation in the labour/employment area sets minimum standards for industrial relations, safety, minimum wages, hours of work, and fair employment practices. Such legislation is virtually universal in coverage of workers over which the federal, provincial and territorial governments have jurisdiction. Since the legislation is broadly similar, it will be described in a general fashion. To do otherwise would involve a discussion of some 55 separate pieces of legislation.

Affecting the labour market but universal in coverage respecting all age groups are the various federal, provincial, and territorial bills, codes, charters, and acts delineating human rights. This section discusses only existing or planned provisions affecting age discrimination.

The bulk of Canada's policies and programs concerning labour/employment have developed in a problem-centred fashion; normally, where targeted, programs have been directed at categories of workers seen as sharing a common problem. For most programs and services, therefore, the client population is comprehensive and includes all workers who share a problem, e.g., skill deficiencies, mobility deterrents, etc. The client population of targeted programs normally cuts across both sex and age groups; e.g., the "chronically unemployed" is simply a category of workers who share similar sets of problems which inhibit employability. In this context, it is fair to say that such programs are comprehensive in that eligibility requirements generally do not discriminate by age or sex of workers.

Industrially targeted programs are usually designed for all workers in the industry but may extend additional benefits to some class or type of workers, including those in an age-specific category. The Labour Adjustment Benefits Program, described later, is an example.

The following descriptions are grouped under two headings: (i) Universal Legislation and Program/Services; and (ii) Targeted Programs/Services.

Universal Legislation and Programs/Services

(i) Legislation Setting Standards

The federal, provincial, and territorial governments all have legislation within their jurisdictions delineating standards in industrial relations, wages and hours, workers' compensation, and general working conditions. Such general provisions provide protection for all workers, including older workers.

(a) Industrial relations

The Canada Labour Relations Board, and various provincial ones, have responsibilities for union certification, successor rights* (if applicable), disputes regarding the introduction of technological change, and all matters subject to collective bargaining for unions under their purview.

(b) Labour standards

Most of the above-mentioned governments have legislation on some or all of: annual paid vacations, minimum wages, hours of work and overtime premiums, maternity benefits, notice of termination, equal pay between the sexes, and occupational health and safety.

Provision is made in the legislation of almost all jurisdictions for the employment of handicapped workers at wage rates below the established minimum wage. This is to give a financial incentive to employ such workers.

(c) Workers' compensation

All jurisdictions have legislation setting compensation standards for workers injured in industrial accidents or as a result of industrial diseases. Medical, hospital and rehabilitation services are provided to injured workers in respect to such accidents or diseases.

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* When a firm is purchased by another firm, the rights of the existing union to continue to bargain may be circumscribed. Successor rights define those rights which are to be continued.

The legislation covers work-related temporary and permanent disabilities among all workers. Those who have a work disability or disease are assured of income support of about 75 per cent of wages during the disability period. They are also assured of medical and hospital care, and rehabilitation services to enable them to resume productive roles both as workers and members of society.

(d) Human rights

One of the provisions of the human rights enactments relates to the prohibition of discrimination in employment because of age. In most jurisdictions, discrimination in employment is forbidden up to and including age 64 under provincial human rights codes. Manitoba's is open-ended. In New Brunswick, the legislation does not apply if employment is terminated because of terms and conditions of a bona fide retirement or pension plan, but it is otherwise open-ended. Quebec has the first legislation in Canada specific to the prohibition of mandatory retirement due to age.

(ii) Universal Programs/Services

(a) Employment services

Federal and/or provincial governments operate job finding and placement centres for all of Canada's workers. Employers are encouraged to register employment vacancies at such centres. Various studies have indicated that workers with lower skills and those experiencing special difficulties are major users of these services; the aged 45 and over population is significantly numbered among such users.

(b) Canada Employment Program/community development projects

The Canada Employment Program provides unemployed Canadians with jobs in community development projects, particularly in areas of high unemployment. Community development associations or corporations, co-operatives, established organizations, individuals, Native Indian band councils and, subject to agreement with provincial governments, municipalities are eligible to receive program funding. Funding provides a contribution to wages and wage-related costs, as well as a contribution to the overhead and capital costs of each project.

(c) Canada Manpower Mobility Program

The Canada Manpower Mobility Program provides financial assistance to encourage the geographical mobility of workers who need to relocate to find work. The program assists the unemployed, the under-employed, and workers facing unemployment. It also assists trainees who cannot take training in the locale in which they live. In 1980-81, about 16,000 clients served were aged 60 or over.

(d) Adult occupational training

Canada's federal Adult Occupational Training Act presently provides for 100 per cent federal financing of occupational training for qualifying adults. All occupational training in Canada is provided under provincial jurisdiction. Agencies such as joint federal-provincial manpower needs committees, provided for under the Act, can assure co-operation in the assessment of Canada's training needs. A variety of types of training is provided throughout Canada under the Act, in institutional or industrial settings or combinations thereof. Type of program and trainee eligibility for the various kinds of financial arrangements available determines the method of financial support. The mechanisms include allowances, unemployment insurance, or, wage support to employers which is the equivalent of wage subsidies during the training period. Virtually all workers in Canada are eligible for such training at one time or another during their working lives.

(e) Work sharing programs

Under the Unemployment Insurance Program (UI), the Canada Employment and Immigration Commission (CEIC) has, since 1977, supplemented the earnings of workers agreeing to share a reduced amount of work during a temporary period of production cut-backs. The workers benefit from a top-up of earnings from the UI fund for each day of reduced work per week. The program encourages employers and employees to enter into specific agreements in this regard with the CEIC. If workers are laid off at the end of a work sharing period, they receive full entitlement to regular UI benefits. The program aims at a temporary solution to work reduction rather than a permanent one.

Targeted Programs/Services

Although labour related, neither retirement planning programs nor pension benefits standards legislation are discussed in this section. The former are discussed in the section on education/culture/ recreation; the latter in income security under the heading "Private Pension Plans".

(i) Vocational Rehabilitation

All provinces operate comprehensive programs for the vocational rehabilitation of persons with disabilities among whom older persons are significant. Except for Quebec, the programs are cost shared with the federal government under agreements signed by the provinces and authorized by the Vocational Rehabilitation of Disabled Persons Act. In Quebec, programs of a similar nature are cost shared to some extent under the Canada Assistance Plan.

The programs enable persons with disabilities to cope with them and to participate as normally as possible in the community. The comprehensive programs include, but are not limited to, assessment and counselling, services and processes of restoration, training and employment placement, maintenance allowances, use of the services of voluntary organizations in the field of vocational rehabilitation, training of counsellors and administrators, and the co-ordination of all activities in the province related to the vocational rehabilitation of disabled persons.

(ii) Industry and Labour Adjustment Program (ILAP)

Early in 1981, the federal government announced plans to implement a three-year $350 million special Industry and Labour Adjustment Program (ILAP). This program is designed to encourage the re-integration of laid-off workers into regular employment. This is a targeted program in which regions or industries facing severe economic disruption are designated as eligible to receive a wide range of industrial incentives and labour market programs. Included in the arrangement is a new Labour Adjustment Benefits Program which will provide income support to certain laid-off older workers to permit early retirement, and a Portable Wage Subsidy Program as described next.

(iii) Portable Wage Subsidy Program

The Portable Wage Subsidy Program is part of the federal government's ILAP and is designed to facilitate the re-employment of those workers (aged 45 and over) who have been laid off in areas designated by Cabinet as eligible for special industrial and labour adjustment measures. A wage subsidy of $2 per hour to a maximum of $80 per week is paid to an employer who hires an individual qualified under the provisions of this program. The duration of the subsidy is 12 months. It is attached to the employee and moves with the employee if there is a change of jobs during the 12-month period. Since the program began in March 1981, 51 persons, representing 19 per cent of the clientele served, were in the 60 and over age category.

(iv) Other Employment Support for Older Persons

Several provinces assist older persons to find employment, and encourage them to provide mutual help or render services to other aged persons. These programs give the aged the opportunity to use their training, experience and skills in paid employment or voluntary service. In Manitoba, for example, the Senior Citizen's Job Bureau - a free non-profit referral service for both employers and employees - helps find jobs for persons aged 60 and over who want part-time, full-time or temporary work. The Seniors' Employment Bureau of Ottawa - Carleton, Ontario, provides an identical type of service to persons aged 55 and over. The Ontario Ministry of Education, through an apprenticeship program, provides opportunities to older persons to do training or consulting work on a short-term basis. In Alberta, two employment services are funded by the province for persons aged 45 years and over ("Opportunity 45" in Calgary and "Over 45" in Edmonton). In addition, two senior centres in Alberta operate services which help retired persons find paid and voluntary work. In one of the centres using the skills of the aged to help other aged persons, a few of the paid staff are over age 60. In New Brunswick, various community agencies are involved in projects similar to those in Manitoba and Alberta; the Moncton Chamber of Commerce has a program to help seniors find employment, and Volunteer Bureaux in all areas are involved in this type of assistance.

A PERSPECTIVE ON LABOUR/EMPLOYMENT ISSUES

Among older workers are those who would like to retire but are institutionally constrained by notions of "usual" retirement age, pension design in general, or by poverty. There are also those who would like to work but who face overt or covert discrimination because of age and/or sex, and who, in addition, may face barriers in attempting to remedy skill imbalances in relation to the needs of a technologically changing economy. These are the aged who drop out, or are kept out, of work activity.

Early Retirement

During the 1970s, the trend towards early retirement accelerated. Many retirees did not, however, leave the labour force; rather they undertook employment on a full- or part-time basis with a new employer. High inflation and high unemployment have had a significant effect in reducing the numbers currently opting for early retirement. It will, however, remain an issue with which society must grapple.

The tendency is to think about early retirement as a waste of human capital resources, because production, growth and development are hindered. Many people, however, are of the view that persons with 30 to 40 years of work attachment have a right to choose alternative lifestyles, including types of voluntary service. The resulting social and cultural contributions may outweigh productivity losses associated with the decision to withdraw from paid employment. To retire early from a job does not necessarily mean complete withdrawal from work, paid or not. In short, the tendency to think of the early retired as embodying unused human capital disregards the contributions of such persons in other forms of activity that may be as productive for society as the job they left.

Forces Leading to Withdrawal from the Labour Force

(i) Discrimination

Discrimination has both direct and indirect forms. For instance, increasing flexibility so as to allow a greater choice in choosing the age of retirement not only allows for early retirement but deferment of the age of retirement beyond Canada's usual age of 65 years. In both the private and public sectors age 65 has become accepted as the norm. But increasingly the validity of using chronological age as the determinant of when an individual shall cease to be employed is being questioned. Age may be neither a fitting nor a just criterion in determining ability to continue in the labour force or engage in a major forced lifestyle change. In the work force, age and ability have to be related specifically to related qualifications for specific jobs. Appropriate standards in both the public and private sectors appear needed if older workers, able and willing to work, are to be able to do so. While, without doubt, the development of such standards poses difficulties, and while many pension plans have age 65 as the normal age for retirement, these problems do not appear insurmountable. New Brunswick and Manitoba, for example, have altered their policies on retirement of public service employees after study of these concerns.

Numerous studies have shown that discrimination against older workers begins in the middle years, about age 45. The image of these workers as "burned out", less vital, less tractable, and more obsolescent is part of the packaging of a youth-oriented society. This image constrains the unemployed "older" worker to lengthy bouts of unemployment even where skills are not necessarily dated in economic terms. Commentators have said that employers preserve a dynamic image through a youthful age profile.

This problem has been addressed by human rights legislation throughout Canada, mentioned earlier, but, in most cases, protection applies only to persons under the usual retirement age of 65. How and whether to extend protection to aging workers is still an issue in most of Canada's provinces except Manitoba, Quebec and to a lesser extent New Brunswick. The Supreme Court of Canada recently ruled that a collective bargaining agreement cannot violate a province's Human Rights Code. There is a possibility, although it is by no means clear, that human rights legislation that prohibits age discrimination only up to age 65 will be found by the courts to be contrary to the Charter of Rights in the Canadian Constitution.

The forces that limit access or incentive to work are many and serve to cause people to drop out, or be kept out, of the labour market. Frequently, among many of the aging, skills are dated. Skills that have been acquired in dying industries or industries where automation replaces workers are seldom transferable. If access to training is difficult or discouraged, access to further employment is denied. If the skill mismatch is accompanied by a geographic mismatch, training without access to mobility (or a desire to move) provides no access to jobs. About training, one researcher has commented for the Labour Market Development Task Force: "it seems unlikely that existing government-sponsored programs cater adequately to special training (including pedagogical) needs that would maximize the effectiveness of any training for this group (i.e., those 45 and over). A more precise targeting of those programs or their components would be a start towards improving the situation ... research into these dimensions of training for older workers is definitely required for policy making." While such comments are training-directed, substitutions of the words "placement", "mobility", and the like would not be misleading. Evidence suggests that the aging are currently under-represented users of training, relocation whether permanent or temporary, and placement services at the federal level.

In other words, it appears necessary to shift the problem-centred approach to the design of programs and services to a more human-centred approach, noting that universal problems cannot always be addressed by a uniformly designed remedial instrument to which all users must adapt. If, for instance, the aged respond to different pedagogical styles or require five months to learn a skill element that those more recently out of school take four months to learn, they compensate for this with job experience, low turnover and low absenteeism. Modifications in style and program length ought to be developed.

(ii) Incentive

Eligibility criteria for federal programs such as the Unemployment Insurance Program, which does not allow those aged 65 or over to insure their earnings, lead to pressures to withdraw from the work force. What conclusions should be drawn about union, employer, and government pressures upon older workers to opt for early retirement with government pension subsidy in mass lay-off situations, in order that more youthful workers may be kept in productive work? While some such measures have benefited workers seeking an opportunity to withdraw, other workers face considerable pressure from co-workers to withdraw. To ensure that withdrawal is indeed voluntary and that continued participation in work activity does not sever nor unreasonably alter the private pension entitlement, the programs that are in place appear to need some redesign.

Among Income Tax Act regulations is one which allows for payment of a pension after 30 years of service on condition that the employee leave the labour force or that the pension allows for limited earnings but lower entitlements when earnings exceed such levels. Given evidence of work activity, should provisions which directly keep workers out of the labour market or arbitrarily lower private pension entitlements be sanctioned at any level of government? If the response is "yes", should Parliament authorize such sanctions in full public debate and require accountability? The design of internal administrative regulations which may propel valuable and productive persons out of the work force is a serious issue that must currently be addressed. Entire industries, e.g., automotive, have pension plans patterned on the "30 and out" rule.

Women

For women who face a highly segregated labour market in terms of pay and industrial/occupational clusters, there is no consolation in the fact that they share all of the problems discussed earlier on an egalitarian basis with older men. If solutions to their problems when they become old are to be found, pay and occupational/industrial barriers will need to be addressed today by all governments. Among the aging, women have the lowest incomes. For many, especially the unattached, this is not a new experience. It is a continuation of an older pattern of poor pay and an occupational/industrial segregation that has not only limited their income and other opportunities when working but kept them poor upon retirement. At a time when women in the labour force are better educated than men and at least as productive as they are, and when there is a national shortage of skills, the removal of pay barriers and other barriers can only benefit all Canadians.

HEALTH

A PERSPECTIVE ON THE HEALTH OF THE AGING

The health of older persons affects, and is affected by, a number of factors including income security, employment opportunities, life within the family and community, leisure activities, living arrangements, and social service needs - all examined elsewhere in this report. The purpose of this section is to consider the health of the aged and the efforts being made to maintain and protect it. The fact, however, that the biological and physiological aspects of human aging are inextricably bound up with the psychological outlook and the social and cultural milieu of the aged, leads to the inescapable conclusion that an holistic approach to health in old age is needed.

At the outset it is well to remind ourselves that aging begins at conception. It is a normal life process and not an illness.

The aged as a group are surprisingly healthy considering the stresses and strains of life. They tend to appraise themselves as being in good health. Persons with specific chronic diseases often regard themselves as being in good health because they can independently and satisfyingly engage in their usual daily activities. Mental outlook has a considerable bearing upon the older individual's well-being and adjustment to physical disabilities.

The majority of the aged remain functionally well until an advanced age. In spite of their afflictions, around 80 per cent are functionally capable of independent living and of caring for themselves. More older persons do, however, suffer from chronic conditions such as arthritis or heart trouble than do those in other age groups, and are more likely to experience disability restrictions on their activities. In fact, three out of four aged persons have at least one chronic condition. Chronic disease in an older person is usually a cumulative build up over the years. Multiple diseases in the aged often complicate diagnosis and treatment.

Ascertaining the health status of the aged is a complex and complicated task. Health is defined in the World Health Organization's basic charter as a state of complete physical, mental, and social well-being and not merely the absence of disease. In an evaluation of the health, thus defined, of any individual or group, limitations immediately become apparent. Such an evaluation will be subjective. Its practical importance will probably be valid only to the extent that it affords comparison with the health of other individuals or groups.

The evaluation of the health of any group is further complicated by difficulties encountered in defining the group. This is especially true with reference to "the aging". When is a person old? Do all become old at the same age? Is the pattern of aging changing, perceptibly or imperceptibly? Answers to these questions are themselves highly subjective.

These and other inherent impediments to objectivity should be recognized in any attempt to determine the health status of the aging. They serve to contribute to information deficiencies in this field.

As distinguished from the subjective appraisals of well-being, objective evaluations are possible on the basis of disease and impairment. The latter, which constitute major elements in health status, are capable of clinical determination and statistical analysis. Even with such data, however, studies show that the correlation between disease conditions on the one hand and illness or disability on the other are not consistent. As noted earlier, many of those with chronic disease consider themselves in good health.

A major clue to health status capable of quantitative measurement is also provided through the data on specific services rendered to people who are ill, such as those in hospitals and nursing homes. Studies have, however, shown that sizeable percentages of those confined to such institutions are admitted because of social rather than medical needs.

Among the objective indicators of health status most widely used is life expectancy. International comparisons of life expectancy at birth are greatly affected by variations in infant mortality. Comparisons at age 65, however, show that there is relatively little difference among the developed countries, although it is noteworthy that figures for Canada stand among the highest in the world. In Canada in 1976, the expected remaining years of life for men at age 65 were 13.95 years, an increase of 0.42 years since 1961; for women it was 18 years in 1976, an increase of 1.93 years during the same period.

A survey to gather information about the health of Canadians of all ages was conducted in 1978-79.* It showed that about 46 per cent of all those aged 65 and over either made no visits, or no more than two visits, to a medical doctor during the 12 months prior to the survey compared to 66 per cent of those from 0 to 64 years of age; just over 20 per cent of those 65 or more made 10 or more such visits, and somewhat over eight per cent of those from 0 to age 64 did so.

One of the innovative aspects of the health survey was its assessment of the physical activity of respondents. Between the ages of 15 and 19, almost 63 per cent of males and just over 53 per cent of females reported that they were "moderately" to "very active"; comparable figures for those aged 45 to 64 were just over 29 per cent for males and about 30 per cent for females; for those 65 and over the percentages were just over 22 per cent and 15 per cent. Survey findings relating activity to health status suggest that the tendency towards reduced physical activity as age increases may be a matter for concern. Although the survey did not establish any clear relationship between level of physical activity and measures of ill health for those aged 44 and under, persons 45 and over who were "moderately" to "very active" were significantly less likely to display behaviours related to ill health.

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* Health and Welfare Canada and Statistics Canada, The Health of Canadians - Report of the Canada Health Survey, Supply and Services Canada, Ottawa, Ontario, June 1981.

Canada, like most European countries and the United States of America, has experienced rapid mortality declines in the elderly population in the last decade. Mortality rates may stabilize at current rates, continue to decline as they did in the 1970s, or improve at an even greater rate. Further, biomedical research breakthroughs in the prevention and/or treatment of senile dementia and osteoporosis could radically change the quality of life for the aged and their need for some form of institutional care.

The estimated annual bed-days per person are 5.3 for the entire population; the corresponding rate for those aged 65 and over is 13.2. Annual disability days which measure short-term disability associated with episodes of illness or injury include bed-days, major activity-loss days, and days when activity has had to be reduced below that usually done for all or most of a day. The population as a whole experiences a total of 15.7 such days per person; those 65 and over,35 annual disability days.

As one would expect, diseases are usually of more consequence for the aged than for younger people. This is in part because changes in disease status may take place very quickly. But old people are subject to the same illnesses, both acute and chronic, both physical and mental, found in younger persons although some diseases are more common in the later years. There are, however, no diseases peculiar to the aged alone. While the prevalence of mental illness is greater among older than among younger age groups, it should also be pointed out that functional disorders occur more frequently among older people than is generally assumed. But because old people are subject to mental deterioration, "senility has become the wastebasket diagnosis for their mental illnesses". Careful studies in many countries have shown conclusively that approximately 50 per cent of their mental illness is functional rather than organic in origin. Depression, often a major component of functional disorders and also often the signal alerting the possible onset of mental illness, should be taken seriously and professional help sought before the illness becomes a full-blown psychosis.

The major causes of death among the aging are ischemic heart diseases, cerebrovascular diseases and cancer. With respect to morbidity, together with the three diseases already mentioned, accidents, respiratory diseases, and mental disorders account for a very significant portion of all hospital patient days. Both the rate of hospital utilization and the patterns of health conditions requiring hospital care distinguish persons aged 65 and over from the rest of the population. Even though they constitute only 9.5 per cent of the total population, they utilize about 35 per cent of the patient days in general and allied special hospitals; their average length of hospital stay is more than twice as long as that of other age groups.

Both the medical and hospital services are heavily utilized by those aged 65 and over. Ontario Ministry of Health data show that in 1976, 16.2 per cent of the services of Ontario physicians enrolled in the Ontario

Health Insurance Plan* were delivered to the aged who represented 8.9 per cent of the total population. Saskatchewan data show that in 1979 the 11.4 per cent of its population aged 65 and over used about 23 per cent of all physicians' services.

Compared to the rest of the population, the aged heavily utilize drug services. They take over twice the prescription drugs per capita in relation to the general population. In the case of non-prescription drugs, the aged use just under twice the number of the average Canadian. Older people are particularly sensitive to drugs, and harmful side effects are common. Drug reactions occur. Because the aged are more likely to suffer from chronic illnesses which may necessitate taking several kinds of medication simultaneously, drug interactions may result.

In 1971, the first full year of the Medical Care Program, total public and private health spending, including all types of services, hospital and institutional care, and out-of-pocket expenses by individuals, accounted for 7.5 per cent of the Gross National Product (GNP). In 1980 it was estimated that the 7.5 per cent of the GNP still pertained for the health sector. In contrast, over the same period, the total health expenditures in the United States of America increased from 7.6 per cent to about 9.1 per cent of the GNP. Estimates made in 1976 showed that health-related costs for older persons in respect to medical care, and for all types of hospital and institutional care facilities, represented 1.6 per cent of the GNP for that year, equalling just over one third of the cash income of senior citizens. Since elderly persons receive a large proportion of their health-related services free of charge to them, their cash incomes would have had to be one-third greater on average to pay for these services.

Disagreement regarding the percentage of the aged in institutional care arises because there is a lack of consensus about such matters as: the number of days a person should have received continuous care in a general hospital before being classified as a "long-term care patient"; and whether aged persons living in commercial congregate living settings such as hotels, or those living in hostels/lodges for the aged where only room, meals and laundry are provided should be counted. As a result, depending upon the decisions taken by those collecting the statistics, not to mention the definition of a "collective dwelling", the percentages quoted range from under six per cent to over 10 per cent. But the trend over the past few years has been to emphasize community services and home care as alternatives to institutional care. In fact the two should complement each other. In those cases requiring intensive or extensive provision of services, the aged may be better served in the institutional setting, and indeed may welcome it.

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* Approximately 90 per cent of physicians whose services are paid for under the OHIP were enrolled in the plan in December 1976.

Some basic comparisons between the findings of the Canadian Sickness Survey of 1950-51* and the 1978-79 Canada Health Survey, mentioned earlier, furnish information that should be useful in planning for the provision of current and future health services. Despite the 28 years intervening between the surveys, the overall level of prevalence of health problems and disability in the population has remained relatively stable. Major differences in the percentage occurrence of health problems are apparent, however, when age breakdowns are considered. While the prevalence of health problems appears to have increased slightly for the working age population (aged 15-64), the prevalence of health problems among children (aged 0-14) has declined by half and for those aged 65 and over has risen by more than half. For both the young and the aged, the prevalence of long-term disability has remained constant. It is reasonable to assume that improvements in living conditions, diet, immunization and health services have contributed to the marked decline in ill health among children. Among the aged, on the other hand, the population has almost doubled over the period, reflecting a much higher survival rate among elderly persons than in earlier years.

Great strides have been made in the development of the health care system in Canada. It appears that generally speaking the health needs of the aged are being adequately met. It is only for a minority with multiple needs that concentrated efforts are required. But long-term health planning for the aged is fraught with many unknowns. Their health resource requirements over the next 20 years will vary widely depending upon experience with these and a multiplicity of other factors. It is certain, however, that the provision of health and social services to the aged will not contribute to national productivity and economic wealth. Instead, their provision should be seen as the mark of a civilized society. Both the public and private sectors are involved. The position to date might be described as confined to the "art of the possible". Using research, education, and the application of new technologies, planning for the future could be a challenge to reach beyond our limitations.

THE CURRENT SITUATION

Responsibility for the regulation of health care, the operation of health insurance plans, and the direct provision of most health services rests with the provincial governments. Although provinces generally assign primary responsibility for health to one department, the distribution of function varies from one province to another. Some provinces have combined health and social services within the same department. Others maintain a liaison between departments responsible for these related services.

At the federal level, the Department of National Health and Welfare is the principal agency responsible for health matters. Generally speaking, it can be said that the department's responsibilities lie in the overall promotion, preservation and restoration of the health of Canadians. The funding arrangements to assist provinces in meeting their responsibilities in providing services to their populations, including the aged, reflect an important feature in the fulfilment of the department's mandate.

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* Department of National Health and Welfare and the Dominion Bureau of Statistics, Illness and Health Care in Canada: Canadian Sickness Survey, 1950-51, The Queen's Printer and Controller of Stationery, Ottawa, Ontario, July 1960.

Hospital, Medical, and Extended Care

Canada does not have a national health insurance plan. Such insurance is achieved through a series of interlocking provincial and territorial hospital and medical care insurance plans which virtually cover all Canadians. Provided that they meet certain criteria established by federal legislation, the plans are eligible for federal financial contributions made through a block fund financial transfer arrangement. Both the medical and hospital services are heavily utilized by the aged.

The elderly population is also the major user of services supported by the Extended Health Care Services Program. It provides block funding contributions to the provinces and territories so that they have greater flexibility in the identification, implementation and development of health services which are complementary to those under the hospital and medical care programs. Included in the Extended Health Care Services Program are nursing home and adult residential care, and the health components of home care and ambulatory services.

The costs of certain health services and institutional care in a home for the aged or nursing home not covered under the block funding arrangements, mentioned above, may be shared with the provinces under the Canada Assistance Plan. The plan's coverage regarding the aged is described in the section dealing with social welfare.

Federal Health Services for Specific Groups

The Department of National Health and Welfare provides or arranges health services for persons whose care by custom or legislation is a federal responsibility. Native peoples, as residents of a province or territory, are entitled to benefits of medical care and hospital insurance. These insured benefits are supplemented by the department in matters such as in helping to arrange transportation and obtain drugs and prostheses.

With the exception of insured hospital and medical care programs, administered by the governments of the Yukon and Northwest Territories, the department has for many years managed health services for all residents of the two northern territories. The services include a comprehensive public health program, the transportation of patients from isolated communities who are referred to medical centres, and special arrangements to expedite communication between departmental facilities such as nursing and health stations, hospitals, and health centres located in the territories.

The Department of Veterans Affairs is responsible for the health services of war veterans. Under the Veterans' Treatment Regulations, veterans who qualify may receive a wide range of health care services. Those who meet eligibility requirements may receive medical, surgical and dental treatment, prosthetic appliances, and domiciliary care at departmental institutions, contract hospitals, and through local community health facilities by the doctor, hospital, pharmacist, and/or prosthetist of the patient's choice.

Provincial Extended Health Benefits

Over time, additional benefits have been introduced in the provincial and territorial health care systems. Many of these are of importance to the aged. They are shown in the Appendix - Provincial/Territorial Governmental Programs and Systems, 1982. The purpose here is to provide a brief overview of the kinds of benefits offered.

Most provinces provide health services at the community level to supplement and complement those available through the provincial hospital and medical care plans. These vary from province to province. They include counselling; advice on nutrition, health care, and accident prevention; nursing; occupational, physical and speech therapies; medical supplies and equipment; and other health related services. These health services, together with the necessary social services, are normally delivered to persons needing them in their own homes or in long-term care institutions; they may, however, also be available in general hospitals, clinics, and health centres.

To aid, encourage, and support provincial initiatives in the development of community care programs, the Department of National Health and Welfare provides consultative services. Emphasis is on the early detection and primary and secondary prevention of disease, the provision of primary care, and the development of support services to maintain physical and social function. Efforts by all governments are directed towards finding ways to improve the availability of, and accessibility to, community health and home care and support services needed to maintain elderly persons in the mainstream of life, to promote the better utilization of long-term care beds, and decrease the costs of services while maintaining the quality of care.

Prescription drugs are available to aged citizens at little or no cost in every province and territory. Some provide them to all persons aged 65 and over, with or without a small deductible fee or co-payment, others to those who qualify because of low income or the need for life-saving drugs.

All provinces and territories provide institutional care for aged persons. An institution may provide residential care, personal care, or nursing care, or a combination thereof. Both health and welfare services are included and range from minimal to more intensive levels of care. Institutional care is discussed in more detail in the social welfare section of this report.

Some provinces and the territories offer other health benefits.

- Newfoundland provides financial assistance to older persons for transportation for medical purposes.

- Of several extended health benefits in Nova Scotia, a limited optometric program is of interest to the aged.

- Quebec has a program for all residents for optometric services; for the purchase, adjustment and repair of prostheses, orthopaedic and other devices when prescribed for a physical defect or deformity; and for breast prostheses for those who have undergone a mastectomy.

- The Ontario Health Insurance Plan provides certain optometric benefits, coverage on a limited basis for the services of chiropractors, osteopaths and podiatrists, and payments towards the costs of physiotherapy and ambulance services. The plan also provides home renal dialysis and home hyper-alimentation equipment, supplies and medication when made available from a hospital in Ontario and prescribed by a physician or the medical staff of that hospital.

- Manitoba provides certain chiropractic and optometric services, and prosthetic and orthotic devices if prescribed by a physician. Transportation costs for emergencies and urgent hospital transfers are subsidized for those in remote northern communites under the Northern Transportation Program. To assist the handicapped in their daily living activities, special devices are provided through the Special Devices Program. The Department of Health provides other services including home care equipment, home dialysis, home oxygen therapy, an ostomate program, and a Life-Saving Drug Program. There are four day hospitals in Winnipeg funded by the hospital plan, and another funded by the federal Department of Veterans Affairs.

- Saskatchewan provides free prosthetic and orthotic devices and their maintenance and repair under the Saskatchewan Aids to Independent Living Program; hearing aids at cost under the Saskatchewan Hearing Aid Plan; optometric benefits; certain dental surgery and other dental services; physiotherapy by private practitioners; and chiropractic services, none of which are limited by dollar amount or the number of services provided. There are two day hospitals in operation.

- Alberta's elderly residents can benefit from the Extended Health Benefits Program which covers hearing aids, medical and surgical supplies, aids in the home, and most of the costs of eye glasses, dental care, and dentures. In addition, available benefits include specified oral surgical procedures, limited optometric, chiropractic and podiatric services, and appliances provided by podiatrists. Aged residents are covered under Alberta Blue Cross without charge for ambulance services, and with cost arrangements established for each of: prescription drugs, home nursing, naturopathic services, clinical psychological services, dental care needed in case of accident or injury, the payment of the differential charges for preferred hospital accommodation, additional hospital and medical care costs for services received outside Canada, and for mastectomy prostheses. Three day hospitals are attached to auxiliary hospitals in Edmonton and Calgary; there is a psychogeriatric day hospital in Calgary; and in 1982 a day hospital will open in Edmonton as part of a geriatric and rehabilitation hospital.

- Additional benefits in British Columbia include orthotic treatments, services of physiotherapists, optometrists, chiropractors, naturopaths, and podiatrists, and extended services of a registered nurse in an area of the province where a medical practitioner is not normally available.

- The Northwest and Yukon Territories provide financial assistance to persons who must travel from their home either within the territory or outside to get medical care and treatment, as well as to an escort if one is needed.

Mental health activities are of prime importance among provincial health services. While these services are provided to the general population, they can be of particular significance to the aging suffering from mental disability. Most facilities are operated by the provinces and include community mental health clinics, psychiatric units in general hospitals, and psychiatric hospitals.

Community mental health facilities have been extended beyond psychiatric institutions to provide greater continuity of care, deal with incipient breakdown, and rehabilitate patients in the community. Psychiatric units in general hospitals integrate psychiatry with other medical care and make it available to patients in their own community. Small regional psychiatric hospitals in some provinces serve a similar purpose. Day care centres, which provide care to patients during the day and allow them to be at home at night, have now been organized across Canada. Community mental health clinics, some provincial and some municipal, and psychiatric out-patient services are open in all provinces.

Specialized rehabilitation services assist former psychiatric patients to function more adequately. These include sheltered workshops that provide work and training, halfway houses in which patients can live and continue receiving treatment while becoming settled in a job, and other facilities.

The Department of National Health and Welfare collaborates with national and international agencies in developing guidelines and undertaking studies in the mental health needs of the aged. The department identifies concerns related to aging and mental health for research and demonstration.

All provinces have rehabilitation programs to assist in the restoration of function of disabled persons so that they can resume normal activities and obtain the greatest possible degree of physical, social and economic independence. Although designed for disabled persons in the general population, these programs benefit elderly disabled persons. Home care programs are part of the rehabilitation network and are available for convalescent patients, the disabled, the chronically ill, and elderly persons who require treatment or support.

Prosthetic and orthotic devices and technical aids are of importance to disabled aged persons. Their proper design and fitting, and the training in their use are critical if disabled persons are to lead normal lives. Much has been done in Canada in developing a wide range of devices and in developing rehabilitation technology to resolve problems of mobility, communication, perception, and learning. The federal government's support of research and development in modern electronic technical aids has played a part in this.

Prosthetic and orthotic services and personal aids are available through Prosthetics Service Centres located in major cities, hospitals and rehabilitation centres, and from several provincial Workers' Compensation Board Centres. Saskatchewan, Manitoba and Quebec have comprehensive programs providing such services. Provincial home care programs are another source as are some voluntary agencies, e.g., the Red Cross provides some items through its loan services.

Provincial Workers' Compensation Programs

Each of the 10 provinces has Workers' Compensation legislation administered by a board or commission which provides for compensation, medical care and rehabilitation for workers injured in industry or affected by occupational disease. By arrangement, federal government employees under federal legislation are covered by the legislation in the province where the employee usually works. These programs are designed for all workers, regardless of age, who are injured on the job or affected by an occupational disease.

Health Protection and Promotion

(i) Health Protection

Legislation in all provinces regulates public health, environmental sanitation, and vital statistics. Provincial health departments, in co-operation with regional and local health authorities, administer a number of services to protect health. Those of specific importance to the aging include environmental sanitation, control of communicable diseases, public health laboratories, and vital statistics. Public health bacteriology (testing of milk, water and food), diagnostic bacteriology, and pathology are the principal functions of the laboratory service, with medical tests and analyses steadily increasing for physicians and hospitals.

Each province has a coroner's, medical examiner's, or equivalent system which impinges very directly upon the health care of the aged. Regardless of the differences that exist between provinces in the organization of the system, its purpose remains the same. In the event of misadventure, it monitors compliance with the regulations which govern sanitation, safety, medical care, and the like, to ensure that standards are observed concerning the aging population.

The health protection services of the Department of National Health and Welfare pertain to foods, drugs, environmental health, and disease control. In respect to nutrition, the department determines, assesses and controls the nutritional quality of foods in relation to human requirements and health, promotes an informed use of foods to improve the nutritional status of Canadians, and is currently revising the Dietary Standard for Canada. The department also studies causes of food poisoning, and recommends the microbial limits for foods, with more stringent limits for those prepared for vulnerable populations including the aged.

The department ensures the safety and efficacy of drugs in accordance with the Food and Drug Regulations by developing specific criteria and guidelines. Regulations control the availability of drugs; relevant information is distributed to facilitate the judicious use and prescribing of drugs. The department works in close association with the provinces. Specific recommendations are made for certain drugs for the aging.

In the area of environmental health, the department ensures that medical devices sold in Canada are safe and effective according to the Food and Drug Regulations of Canada. Examples of devices used by the aging include replacement joints, hearing aids, cardiac pacemakers, intraocular lenses, mobility aids, and communication and daily living aids. In respect to chemical hazards, the department is concerned with the health effects of chemical and microbiological agents in the environment, other than food and drugs. The aged are considered to be at risk from all environmental chemical hazards due to their prolonged exposure to the environment. Dealing with control of the pollution of the environment at the federal level is the responsiblity of the Department of the Environment. It shares this with the provincial governments where responsibility rests for environmental quality, including clean air and water, and with other federal agencies having specific responsibilities for the protection of the environment.

In the area of disease control, the Department of National Health and Welfare monitors the morbidity and mortality of communicable and non-communicable diseases in the Canadian population. The department recommends that all persons aged 65 and over receive influenza vaccine annually; the use of pneumococcal vaccine for aged persons is currently being reviewed. Information is provided to consumers regarding the effects of foods, drugs, and medical devices on their health and safety.

(ii) Health Promotion

The Department of National Health and Welfare and provincial departments of government promote lifestyles to improve the personal health of Canadians, and encourage the development of community health programs. Major areas of health promotion involve the non-medical use of drugs, including alcohol and tobacco, nutrition education, and general approaches to improving lifestyles.

Federal and provincial governments co-operate in a national alcohol information program using all the advertising media, and work together in reviewing the problems related to alcohol and in developing standards for alcohol advertising. The federal government's alcohol program includes "Dialogue on Drinking", and a recently-issued special report of statistical data regarding the use of alcohol. This study includes the aged among the groups at risk. Another resource developed in the Prairie Region of the Department of National Health and Welfare is a slide-tape presentation entitled "Drugs and the Elderly". A long-range plan to develop information on smoking and health has been carried on co-operatively between the federal government and the Canadian Council on Smoking and Health.

To promote better health, health risk assessments have been designed to help individuals identify aspects of their lifestyles which may lead to immediate or longer-term risks to health. The hope is that changes will be made which will eliminate, or at least reduce, these risk areas. The department operates EVALU*LIFE, a computerized risk assessment counselling tool, for use by health professionals.

The department tries to reduce the number of Canadians who are "at risk" because of poor dietary habits by promoting an informed use of foods in an effort to improve nutritional status. Programs include maintenance, evaluation, the revision of Canada's Food Guide, and the implementation with the provinces of the "Nutrition Recommendations for Canadians" as accepted by federal and provincial health departments. Further, the department has developed a nutrition program for use in pre-retirement preparation seminars offered to employees in the Public Service of Canada. Plans are under way to make this program available to industry and to other governments.

A PERSPECTIVE ON THE HEALTH ISSUES

The health issues identified in this section are those that are specific to the aging. Health, for the aging individual, goes beyond the concept of the absence of disease. It involves complex biomedical, psychological and social factors, some of which are related to organic, physiological changes associated with normal aging; others are related to disease states, the causes of which are only now beginning to be understood, treated and increasingly prevented; and still others are related to the socio-environmental situations of older persons. Because of the interdependence of these factors, physical, mental, and environmental health cannot be viewed as separate states of well-being or illness among older persons.

Looked at from this perspective, the health care system should promote the highest possible functional independence and health among the aging, provide appropriate care in an integrated and co-ordinated way, ensure equitable and reasonable access to appropriate services, and provide for the needs of those among the aging who require special care.

Health Promotion

An issue of some importance is the effect on the health of Canadians in general, and the aging in particular, resulting from the imbalance in the allocation of resources for the treatment of disease as opposed to health promotion, protection and the prevention of disease. A 1974 publication of the Department of National Health and Welfare* states that physicians, surgeons, nurses and hospital staffs spend much of their time treating ills caused by adverse environmental factors and behavioural risks - illnesses which could be prevented. It also says that the increased availability of health care services in Canada depends to a large measure on the success achieved in preventing illness by measures taken in human biology and lifestyles.

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* Lalonde, Marc, Minister of National Health and Welfare, A New Perspective on the Health of Canadians, Department on National Health and Welfare, Ottawa, April 1974.

Health promotion aims at improving the health and well-being of Canadians. Such improvements could enhance the capability of the aging to live independently in society for longer periods of time than formerly, and to assume a greater responsibility for personal health care and for improving their well-being. While more emphasis on health promotion might directly improve the health of the aging today, in the long term, it can be expected to result in more healthy members in the aging population of the future.

Health promotion should begin early in life. Much of the lack of function and restriction of activity in old age is the result of heart disease, hypertension, respiratory problems, and other chronic conditions brought about by smoking, inappropriate diets, excessive drinking, and lack of exercise. Modification of these behaviours, starting even at middle age, can substantially improve the quality of life of older adults in their later years.

Accidents, especially falls, are among the leading causes of morbidity among the aged. Most falls, and many other types of accidents, are due to the onset of disease or to normal deterioration of physiological process and function, particularly those related to sensory deficits and psycho-motor performance. A good proportion of accidents might, however, be avoided through changes in the home environment and increased safety awareness by the aging and by persons in contact with them.

Disease prevention is also important for the aging. One aspect relevant to their health is the development and use of vaccines, such as influenza vaccine and others that prevent serious respiratory illness.

Physical and mental fitness for the aging are proper goals for a health promotion program, and should focus on restoration and rehabilitation. Mental disorders are highly prevalent among the aged. These conditions may be precipitated and aggravated by loneliness, isolation, loss of spouse or other family members and peers, and by deteriorating health. Depressive disorders may be misdiagnosed as organic brain syndrome and could result in unnecessary permanent institutionalization of an older person. Many of the life issues and problems which must be faced by the aging can be anticipated. Consequently, it is very practical to plan for them in order to make the necessary adjustments.

Much more needs to be done to cope with mental illness among the aging by providing more and better psychiatric services. The lack of these services is borne out by 1976 data from the Ontario Ministry of Health. They show that only 4.6 per cent of the services rendered by psychiatrists were devoted to the aged; and in institutional care, aged persons constituted only 5.8 per cent of all psychiatric patients. The need for better psychiatric services is substantiated by two recent Saskatchewan studies, one of elderly patients in all extended care hospitals in the province, the other of residents in homes for special care.

The aging need to be better informed not only about the normal age-related processes which can be expected over the life cycle, but also about the personal measures that can be taken to cope with these. More intensive and extensive education, as well as better dissemination of information, would greatly assist the health and social functioning of aging persons in Canada.

Health protection is important to the aging because of health hazards associated with food and drugs. The area of pharmacokinetics (how drugs are handled in the body) with consequent modification of drug dosage for the aging patient is particularly relevant. Proper packaging and labelling of drugs, and the monitoring of adverse drug reactions and accidental poisonings are other matters of concern. There is need for on-going evaluation and control of a variety of medical devices, many of which are important to the aged. Improvement in their availability, safety, and efficiency makes it easier for many older persons to lead a relatively normal life in their own homes. The nutritional quality of foods in respect to the special needs of the aged, as well as those of other groups, is important in the development of food regulations.

Health Services

The availability of adequate health services is only one factor affecting the health and well-being of the aging. A number of other factors are also important including income, social services, housing, transportation and employment. But the adequacy of health services may be affected by factors such as co-ordination, communication and integration; their differential distribution between urban and rural communities; the differential provision of services between provinces and within provinces; and the lack of consultation with the aging about their needs.

Co-ordination is a major and central issue in the area of health services for the aging. The need for better and improved co-ordination exists in the planning, development, and implementation stages of policies and programs, and in the delivery of services. Federal, provincial, and municipal governments are involved in some or all of these processes, as are a number of agencies in the private sector. The inevitable result of the lack of effective co-ordination is unneeded competition, duplication and overlapping of programs and services between and within governments, and between governments and private agencies. Important to effective co-ordination is consultation. While there are consultation networks between federal and provincial governments, an overall network for on-going consultation is required among all of the agencies of government concerned with health policies and programs for the aging, and among the agencies of government and those in the private sector.

Associated with co-ordination is integration. Some provinces have already moved a considerable way in integrating health and social services delivery at the community level. Integration needs to be improved country-wide. Better co-ordination and integration should not only meet the needs of the aging more adequately, but at the same time should bring about economies in the use of fiscal and manpower resources.

The uneven distribution of health services between provinces, as well as the larger urban centres and smaller urban and rural communities within provinces, is an issue of concern. This occurs because larger sized health facilities are located in the areas of greatest demand for health services, and because physicians, surgeons, and other health personnel tend to locate more readily in larger population centres and certain provinces. Recently the Economic Council of Canada reported the wide variations in the level of health expenditures and health services among provinces. These resulted because of the differences in the number of practising physicians per capita within provinces, which in turn had an important bearing on the level of available hospital services between provinces.

Another issue has to do with differences in the range of health services provided by each province and territory. There are variations in the provision of hospital and institutional care, community care and extended health benefits. The aging often constitute the largest group of beneficiaries of the available services. Where an aging person lives may determine the array of health service entitlements, as is the case for persons of any age.

Historically, the aged have rarely been consulted about their needs. There have been very few mechanisms in Canada to allow them to have a voice in matters of importance to their welfare. Decisions about the needs of the aging have been left to the middle-aged and younger members of society. Recently, however, jurisdictions at various levels have established consultative and advisory bodies which are endeavouring to involve the aged more effectively in decision making regarding the planning, development, and delivery of the services of concern to them.

Access to Health Care

There are a number of contributing factors that limit access to health care by the aging. Included are Canada's widely dispersed population, the lack of transportation in some areas, the long cold winters, and language and cultural differences. While there are problems of access in urban centres, these are likely to be more difficult in rural and remote areas. In the remote areas of the North, serious health problems usually involve transportation by air to medical centres in the cities of the South. In consequence, some persons may deny that they are sick, or not seek medical help to avoid being sent for care in institutions or in centres in the South that will inevitably involve separation from family, friends and their home community.

Another factor limiting access to services by the aging can result because of differences in language and culture. Since there are older persons who do not speak English or French, making known their needs for services may present difficulties. On the other hand, aged persons who speak English and live in areas which are predominantly francophone, or who speak French and live in predominantly anglophone areas may also experience difficulties. Further, a person's cultural background may be an impediment in achieving needed health services, particularly in unfamiliar cultural surroundings.

Attitudes that reflect a systematic stereotyping of, and discrimination against, the aging simply because they are old have been designated by the term "ageism". It holds that there is a direct relationship between chronological age and physiological/psychological health and that therefore many, if not most, of the physical, mental and social impairments suffered by the aged are inevitable effects of aging and are irreversible. Those who subscribe to this concept, whether consciously or unconsciously, including health care personnel, may create barriers for the aged in gaining access to appropriate levels of health care. For example, problems may be experienced in obtaining rehabilitation services because they are not considered to be productive workers; and simply because they are old, in getting adequate intensive and extensive care if they are ill. They, like those of any age, may find that they are being treated in a depersonalized fashion if they are terminally ill or appear to be dying.

An issue that is due partly to attitudes and partly to lack of information is the difficulty experienced by some older persons in having their health problems adequately assessed by physicians, surgeons, nurses and other health care personnel. While the situation has been improving in recent years, much remains to be done in order to focus attention on the aged in the health care and health service delivery systems. Inherent in this achievement will be improved gerontological and geriatric content in the education of health professionals. Professional teamwork will also be needed in the care of the aged, as well as the development of more accurate assessment techniques in the field of aging.

The aging in Canada are generally well covered under the health care system. They are entitled to all the services provided under the medical care and hospital insurance plans, and to a range of extended health benefits with little or no charge.

There are circumstances when extra costs can arise and pose problems for the aged with limited incomes. The costs of transportation to visit doctors or treatment facilities when public transit is not available, or when other and more expensive means of transportation have to be used may create problems. Extra billing by physicians in certain provinces, payment for laboratory, radiological, and other diagnostic health services, and the cost of special diets required in the treatment of certain conditions may present financial difficulties for those on already limited budgets.

Per diem charges levied in long-term care institutions can bring about financial difficulties for the aged in certain situations. When a person in an institution has to maintain a home in readiness for discharge, or when one spouse is institutionalized and the other remains in their home and maintains it, probably on a low level of income, financial problems may occur.

When an older person requires care from the family, the costs may be both human and economic. Respite care to assist families who care for their aging members may be limited, and many such families are neither assisted financially nor provided with adequate social service support.

The costs of eyeglasses, hearing aids, dental care, prosthetic and orthotic devices and other medical appliances and services may simply be too heavy to be borne by aging persons who may require them. While they are available without charge in some provinces, costs have to be incurred in provinces not providing these extra benefits.

The fee-for-service method of payment of physicians reflects an emphasis on acute episodic care, and may not represent an incentive for physicians to provide long-term continuing care. Payment is based on units of service; in its present form it may not be appropriate for cases requiring prolonged and detailed assessment of medical, social and family issues involved in individual care. The implications of new types of remunerative arrangements which take into account the multidisciplinary team approach to continuing care should be studied.

Care of the Terminally Ill

There are a few hospices in Canada providing care for the terminally ill and more are needed. The emphasis in hospice care is on meeting the needs of the dying patient. Efforts are directed at reducing the physical, emotional and psychological pain of the patient. Care also extends to members of the patient's family. The aim is to create a humane environment for everyone involved in the care of the dying patient.

Hospice facilities may be developed either as separate institutions or as special units of existing institutions. There is as yet insufficient personnel with the specialized training required to staff such facilities. Many terminally ill persons, however, die at home, in hospitals, and in institutions for long-term care and will continue to do so. Doctors, nurses, and other care-giving personnel need training to help them in providing more supportive care to dying patients and their families.

The development of an acceptable definition of death is an issue of some concern. Such a definition is most important for the medical and legal professions, as well as for Canadians in general. The Law Reform Commission of Canada has published recommendations regarding this.

Care of the Aging

Special efforts are needed to provide services for the group aged 80 and over which is expected to grow at an average annual rate of 2.9 per cent to the end of the century. This population group, characterized as it is by a proportionately larger number of women, will continue to be among the most vulnerable. There will be a certain number of physically and/or mentally impaired persons in this group without family support who will require institutional care; it should be provided when deemed necessary. Efforts should be made to ensure that institutions are responsive to the needs of older residents; they should provide the best level of care possible outside the family setting.

The current trend is to admit to institutional care only those persons for whom its necessity can be clearly demonstrated. It therefore behooves governments in Canada to consider how, and to what extent, comprehensive and co-ordinated community care programs can best be developed. Most provinces have developed, or are developing, home care programs that include health and social services delivered in the home, frequently in co-operation with voluntary and/or commercial agencies. Such programs benefit the aging because they enable them to stay at home and/or to shorten hospital or nursing home stays. Participants in the programs are often better served through a combination of family and community intervention than in a hospital or other form of institutional facility. The need for the further development of policies, aimed at supporting the aged and their families in their familiar habitats through a broad range of community services, is a major humanitarian issue.

Making optimal use of volunteer services and voluntary agencies in the delivery of services at the community level is an important matter for consideration. The voluntary sector has pioneered innovative approaches in the delivery of services to elderly persons and other target groups, for example, meals-on-wheels, wheels to meals, telephone checking and reassurance services, and the like. Volunteers are a most important resource today and in the future. It is important to find ways and means to support their existing contribution to the health care system, and to expand the use of volunteer services by the aged and to the aged.

Planning for the Future

Some of the major health issues of concern to governments in Canada as they plan for an aging population have been outlined. Within the constraints of available resources these governments have addressed some of them; but all recognize that much remains to be done. A clear delineation of the gaps and deficiencies that can currently be identified by each jurisdiction may be the immediate task. The establishment of priorities for action would follow. Obviously in the face of the severe competition for financial resources each government now faces, and presumably will continue to face in the years ahead, meeting the challenges in providing for the health needs of an aging population may present some difficult choices.

HOUSING/ENVIRONMENT

THE LIVING ARRANGEMENTS OF THE AGING

The aged live in as many different locations and in as many different kinds of living arrangements as is the case with any other age group. Like people of other ages they want a variety of kinds of housing ranging from single family dwellings and apartments to institutional living and the like. Some seek neighbourhoods offering multigenerational living; others prefer to live with their peer group.

Among the aged there are those whose "family" consists of a spouse. Others live alone, in extended families or in some form of communal living. These various "family" compositions are discussed in the section dealing with the family.

The rate of home ownership among the aged exceeds that of the younger population. In 1976, about 1.2 million Canadian households could be identified as having a "head" 65 years of age or over. About two thirds of these heads owned and lived in their homes alone or with their families (usually a spouse). Furthermore, the home is usually the only major physical asset of older persons. Only about 10 per cent of the aged who own homes have mortgages, though proportionately twice as many elderly women as men have some mortgage debt.

By sex, just over half of elderly women "heads" and over seven in 10 male "heads" claim ownership. These figures should, however, be viewed with caution since the statement of who is the head of a household is a subjective decision. Further, it is entirely possible that the "head" so identified may not be the legal owner or title holder of the property.

Census figures on home ownership, combined with census data on older persons who lived in institutional settings and evidence that many elderly women lodged with families established by their children, indicate that well under a third of the total elderly population were renters in 1976. The Survey of Consumer Finances for 1979, which does not survey the aged institutional population, suggests that just over a third of the non-institutional population 65 and over were renters, and another five per cent were lodgers.

The housing owned by aged persons is generally the older stock by Canadian standards since half was built before 1940. The vast majority (85 per cent) is single family detached and, as a consequence, could be considered large in size relative to the needs of the owners. Size and age make such housing difficult to maintain and heat. The housing of renters is generally quite different. Most elderly renters live in apartments, many of which are quite new since half were built since 1960. Nearly all apartments (94 per cent) are one- and two-bedroom units.

Elderly owners are generally better able to afford their housing than elderly renters, yet there are still considerable numbers of both groups who spend a significant proportion of their income on housing. According to a 1978 survey, one quarter of elderly owners spent more than 25 per cent of their income on housing, compared to nearly half of elderly renters, for whom housing costs exceeded 25 per cent of their income. For those who are owners, housing costs include mortgage repayments, if any, property taxes, maintenance and heating costs. The better housing affordability position of the elderly homeowners is partly reflected by their higher incomes which, for family households in 1976, averaged $12,200 for owners as opposed to $9,400 for renters; and is partly because of their lower housing costs which averaged $1,800 for owners versus $2,300 for renters in 1978 among family households. In addition, a house represents a substantial financial asset - an average of $37,000 according to 1976 figures. About 21 per cent of elderly renters spent over 40 per cent of their income on shelter in 1978.

Relatively twice as many women "heads" as men "heads" rent apartments, and three quarters of these women are widows. For many of them, as well as many of those men and women who are in the late later years, apartments are an attractive option - someone else cuts the grass, clears the snow, maintains fixtures, and geographically, even when not centrally located, apartments today are frequently close to shopping centres, recreation facilities, and transportation. The fact that apartments may be age-integrated or age-segregated, and that they may be found in age-integrated or age-segregated neighbourhoods, makes them an attractive option for people with diverse tastes. But the aged live in both apartments and single family dwellings. Both may be found in the age-integrated community; both may offer age-segregation opportunities, for example, in an apartment building per se, or in a retirement community. An age-segregated arrangement can offer an appropriate milieu in which elderly persons can develop friendships and participate in social life with their own peer group. When living accommodation is in age-integrated residential areas, generational and intergenerational fellowship may be enhanced.

Ironically, the aged in publicly subsidized housing are often de facto in an age-segregated environment. That some welcome this while others complain about their social isolation from broader society is an indication of diverse human natures.

Institutional care is an option if not a necessity for a minority of the very old population, particularly those with no families or with serious health conditions that cannot be addressed adequately through home care and/or other social support services. Institutional accommodation is discussed in both the health and social welfare sections.

Housing and transportation are interrelated concerns of Canada's aging population. While nearly three quarters of Canadian households reported automobile ownership in 1976, data on urban families for that year showed that only about 60 per cent of married couples aged 65 and over, and about

18 per cent of the unattached aged, owned automobiles. Ownership also was shown to decline markedly with age. The consequence is that many of the aged rely heavily on public transit, family, and friends to meet their transportation needs. With one quarter of the aged in rural areas, and the remainder in urban areas with populations over 2,500 persons, meeting the transportation needs of the aged will vary significantly as a result of location, the numbers to be served, the costs of an appropriate service, and other elements of a similar nature.

THE CURRENT SITUATION - HOUSING OF THE AGING

Federal housing policy in Canada is mainly the responsibility of the Canada Mortgage and Housing Corporation (CMHC), established in 1946 to administer the National Housing Act (NHA). With few exceptions, however, the CMHC works closely with the provinces, sharing the costs of activities with them under differing formulae. Thus, provincial funding, for example, in providing housing assistance under NHA auspices can loom as large as the federal share. Furthermore, the provinces assist renters and homeowners without federal assistance in some of their programs. The upshot of the co-operation, co-ordination, and joint funding is that it would be a misnomer to call most assistance under NHA auspices as federal activity. It is, rather, federal-provincial activity. While the basic federal objective at this time is "to ensure that all Canadians have access to adequate housing at a cost they can afford and in a sound community environment", it is nonetheless the case that policies and programs respond to changing federal and provincial government objectives as well as changing social and economic conditions.

The aged have traditionally been one of the primary recipients of federal and provincial housing assistance. Often, policy initiatives under the NHA have focused on the provision of subsidized rental accommodation for senior citizens. Assistance offered has two forms: (i) loans made, often at reduced interest rates, for the construction of units for senior citizens, and (ii) on-going subsidies available to reduce rents in these units to a level compatible with the low-income position of many elderly families. Some of these programs are cost shared with the provinces on a 50:50 or 75:25 basis.

Between 1947 and 1980, the federal government loaned or insured loans valued at $2.5 billion to provide rental accommodation for elderly persons in Canada. Provincial shared cost activity is also very large. This activity has occurred through public housing and non-profit and co-operative programs and has resulted in almost 138,000 rental units and 46,000 hostel beds*. The CMHC has estimated that its share of the ongoing subsidy to reduce rents in these units was close to $160 million in 1980.

Since 1974, the federal government has offered assistance to homeowners through a unilateral program, the Residential Rehabilitation Assistance Program (RRAP). Elderly homeowners have been one of the primary users of the program. By May 1981, close to $118 million in loans had been made to households of persons aged 65 and over to assist with dwelling repairs. Close to 90 per cent of these loans had been forgiven and close to 34,000 elderly households had received assistance through the RRAP. Similar provincial programs are described later.

Most provinces, either in co-operation with the federal government or using their own resources, provide assistance to increase the supply of housing for elderly persons and to provide financial assistance for housing rehabilitation and repair. Many provinces and municipalities also assist elderly homeowners and home renters by rebating school and property taxes or providing opportunities for their deferral, and some provinces provide cash assistance and allowances to elderly renters.

The discussion of programs which follows will outline assistance available to elderly renters and homeowners through federal and provincial initiatives. Many of these programs are not specific to the aged; they are available to other groups of low-income Canadians.

Assistance to Renters

Federal assistance to renters comes primarily from two sources: (i) federal/provincial public housing under Section 40 and Sections 43/44 of the NHA; and (ii) federal non-profit and co-operative housing. Although some modest assistance for the aging has also occurred under Section 44(1)(a) whereby privately-developed housing is leased by the provinces and then rented to needy tenants (called federal/provincial rent supplement) and also under Section 40, Federal/Provincial Rural and Native Housing, the amounts of senior citizens' rental accommodation provided under these sections has been too low to make extended discussion necessary.

(i) Federal/Provincial Public Housing

Under Section 40 and Sections 43/44 of the NHA, the objective is to provide housing for low-income individuals and families on a rent-geared-to-income basis and thereby increase the proportion of the housing stock available to low-income people; and, to encourage this activity in conjunction with provinces, municipalities and their agencies.

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* "Hostel beds" refer to accommodation in homes for the aged, lodges, hostels -- many names for such institutions are used. Included are many nursing care beds. But these institutional beds do not represent the total number of beds available to those requiring institutional care. Excluded are institutions under private auspices operated for profit. These represent thousands of beds in which many persons receive care, often supported financially through the Canada Assistance Plan and by the provinces.

Under Section 40, the costs of programs for subsidies and ownership are shared on a 75:25 ratio between federal and provincial governments. (Municipal governments may also contribute to the provincial share.) With Sections 43/44, the federal and provincial governments share the capital costs on a 90:10 basis and ongoing subsidies are shared on a 50:50 basis. The federal rent-to-income scale ranges from 16.7 per cent to 25 per cent of tenants' incomes. Access to this accommodation, which is designated for "senior citizens", is age-related. In some provinces, access is set at 55 years of age; in others, it is 60. The type of accommodation may be bachelor, one bedroom and, occasionally, two bedroom in size. Depending on the size of the community, buildings can range from ground-floor oriented and walk-up apartments to units in a building with an elevator. Some projects also include funding for social and recreation facilities for seniors. All loan activity under Sections 43/44 was phased out on December 31, 1978, with the exception of the Northwest Territories, where it is still operational. The bulk of senior citizen housing in Canada was built under this section of the National Housing Act.

(ii) Federal Non-Profit and Co-operative Housing

Under Section 56.1 of the NHA, the CMHC trys to provide modest affordable housing appropriate to the needs of low- and moderate-income families and individuals.

The Section 56.1 activity includes support for public or private agencies offering institutional care to those who need a protected environment. It is the shelter portion of the capital cost that is funded under this social housing program. Residents have a bedroom which may be shared by others, as private living quarters. Mortgages can include 20 per cent of the residential area for social and recreation space, with 15 per cent of the costs allocated for such uses.

Capital funding for the program is obtained through approved lenders in the private sector, with loans insured through the CMHC under Section 6 of the NHA. Assistance is provided in the form of a housing subsidy which, at its maximum, is the equivalent of a reduction from the current market interest rate to an interest rate as low as two per cent and is based on 100 per cent of the capital costs of the project (or 90 per cent for provincial housing agencies) amortized over 35 years. To the extent that the assistance exceeds the differences between economic rent and the low end of market rent, the surplus is available to support tenants who cannot afford market rent or who require a rent geared to income.

The program, particularly the non-profit element, has been used to provide housing for senior citizens. However, the aged themselves have not used the co-operative program to its full potential; although where it has been used in British Columbia, Quebec and Ontario, the experience has been positive.

(iii) Provincial Housing Programs

Most provinces have programs providing rental housing to elderly persons. Many of these projects have been initiated through federal/ provincial housing programs outlined above. Some programs have provided housing, usually at age 65, with some provinces providing these units as early as age 55 and others at age 60. Rentals are geared to income but flat, lower than market, rentals are often charged. The housing programs of several provinces are outlined below.

Alberta's housing program as of March 1980, had 6,553 self-contained apartments, with a percentage designated to accommodate persons in wheelchairs, available to those aged 65 and over; an additional 3,436 units were under construction. The program's capital budget for 1979-80 was $62 million. The lodge program with 120 lodges, each designed to house 45 to 65 elderly persons who no longer wished, or who were unable, to maintain a home or apartment had 6,632 beds in operation in March 1980, 491 additional beds under construction, and 484 self-contained cottage units attached to the lodges. For 1979-80 the capital budget for the lodge program was $7.2 million; in addition nine homes for special care, housing 500 persons aged 65 and over, were provided deficit funding of about $240,000. It should be noted that senior citizens are given priority for all bachelor and one-bedroom low-rental units built by non-profit corporations and developers.

The Yukon Territory through the Yukon Housing Corporation, has a housing program providing self-contained apartments for persons aged 60 and over with 104 units in January 1982 and 4 units under construction.

Manitoba provides subsidized housing for elderly persons aged 60 and over (in special circumstances to those in their 50s) in 7,230 units (10 per cent for couples) at a cost of $5 million in 1979-80. The province also provides capital grants at five per cent of approved developmental costs to non-profit organizations building housing units for senior citizens. There is also a large rent subsidy program [#44 (1) (b)] in which 3,000 units are eligible for rent subsidy within the provincial appropriation.

Saskatchewan, in co-operation with the federal government, through its Non-profit Housing for Seniors program and Public Housing program, has contributed to the capital cost of low-income housing units for elderly persons (708) at a cost of about $6 million in 1980-81; has provided some 4,500 subsidies for rentals of low-income housing at a cost of $2.3 million in 1980-81; and provided in 1980-81 just under $1 million in grants to non-profit sponsors of senior citizens' housing.

Nova Scotia has a broad-based Rental Assistance Program for the province's aged population. The amount of rental assistance will range from 50 to 75 per cent of the rent in excess of 30 per cent of income. In effect, low-income singles and couples may receive up to $95 and $111 per month respectively.

New Brunswick, through the New Brunswick Housing Corporation (NBHC), provides public housing for persons aged 65 and over, charging rents geared to income. There were about 1,935 units available in 1979-80.

Quebec has a program of subsidized housing for low-income elderly persons which aims at providing adequate housing at rents which can be afforded. This program is supported by a program of home rehabilitation and assistance with rentals to low-income persons.

Ontario administers municipal non-profit housing to assist non-profit housing corporations, owned by municipalities, whose main objective is to supply low-to middle-income rental accommodation for families and individuals. The Ontario Ministry of Housing, its Corporation and other authorities have a rental portfolio of about 63,000 units designated for senior citizens, with more under construction. The operating subsidies for these are shared on a 50:50 ratio with the federal government. For the aged, eligibility is for those 60 and over, and the rent ranges generally from 20 to 25 per cent of tenants' incomes. There is also a shared-cost rental supplement program run by the Corporation.

(iv) Provincial Shelter Allowance and Property Tax Programs

Several provinces provide rental assistance as grants, supplements or allowances to persons aged 65 and over, and several provide arrangements enabling homeowners to defer property and school taxes or to exempt them from their payment. These arrangements, such as shelter allowances, are discussed more fully under the income security part of these papers. Shelter allowances are subsidies provided to the aged (usually in receipt of a Guaranteed Income Supplement (GIS) or Spouse's Allowance (SPA)) to defray the impact of high owned or rented shelter costs. Generally, the exact amount of benefit depends both on income and shelter costs.

Assistance to Homeowners

(i) Federal Residential Rehabilitation Assistance Program (RRAP)

The federal government provides forgiveable loans to homeowners and landlords primarily in designated RRAP areas as well as to non-profit groups to bring deteriorating older housing up to minimum standards. This program is designed to improve the quality of the housing stock and to make the homes more liveable and more comfortable for the owners. Loans of up to a maximum of $10,000 are available with a maximum of $3,750 being forgiven, depending on the homeowner's income. Borrowers with $9,000 or less are eligible for the maximum loan forgiveness over a five-year period - the amount forgiven declines to zero at an adjusted family income of $16,500. For landlords, 50 per cent of the cost of repairs up to $2,500 per unit may be forgiven over a 10-year period.

Loans are granted to correct structural, fire safety, electrical wiring, plumbing, or heating defects and to introduce accessible features for disabled persons. Other improvements, such as installation of insulation or improved thermal efficiency, are possible. This program has been heavily used by elderly residents of owner-occupied homes.

(ii) Provincial Rehabilitation Programs

There are programs in several provinces that provide financial assistance for the repair and rehabilitation of homes. Most provincial programs are primarily directed to needy and elderly persons or generally serve this group and are designed to make their homes more liveable and comfortable. A description of some of the provincial programs follows.

Alberta provides grants up to $1,000 to modify existing homes and to permit handicapped homeowners to adapt homes in respect of lifts, ramps, grab bars and so on; and under the Alberta Pioneers Repair Program provides up to $2,000 to eligible senior citizens whose incomes do not exceed $13,500 for home repairs, improvements and restoration. Alberta also has a program which provides interest subsidies on loans of up to $10,000 each for self-contained suites and $5,000 each for light housekeeping rooms to assist homeowners in building rental suites in their homes. These are seen as aiding senior citizen homeowners as well as persons who may wish to add a suite to accommodate an elderly relative.

The Yukon Territory has a program of dwelling restoration which is designed to help restore the dwellings of low-income family homeowners.

Saskatchewan has a program of residential rehabilitation to provide low-interest loans of up to $8,000 to homeowners whose family income is less than $16,500 for upgrading property to the standards of the Saskatchewan Housing Corporation; and, under the Senior Citizen Home Repair Program, provides grants to a maximum of $650 to senior citizens to make minor repairs to their homes.

Manitoba has a Critical Home Repair Program (CHRP) which provides loans and grants of up to $1,500 to owners of older homes to make urgent repairs. Pensioners aged 65 and over are one of the recognized groups under this program. Low-income families in the 60-64 age group are also covered.

Ontario has a Home Renewal Program to provide loans and/or grants of up to $7,500 through municipalities to owner occupants to bring their homes up to municipal standards. The rate of interest charged on the loan is determined by annual family income.

Quebec has a program of dwelling restoration which is designed to help restore the dwellings of low-income family homeowners.

New Brunswick provides home improvement loans (as provincial loans and as combined federal and provincial loans) for persons aged 60 and over, up to $7,500 with no interest being charged and repayable over 15 years.

Nova Scotia has a Senior Citizen's Assistance Program for seniors wishing to remain in their homes but unable to afford repairs which would enable them to do so. While geared to income, assistance is in the form of forgiveable loans of up to $3,000 over a five-year term. There are normally no cash repayments at the end of this term as loans will be forgiven at the rate of $50 per month for continued occupancy and ownership of the repaired home. As well, Nova Scotia has an Access-A-Home Program to subsidize, for the most part, the bulk of costs involved in eliminating architectural barriers that impede the use of wheelchairs. Some of the aged benefit significantly from this program.

Other programs, such as the Housing Emergency Repair Program, provide grants of up to $2,000 for emergency repair. In addition, Nova Scotia has a small loans program for repairs, alterations or additions to single-family homes or for their completion. Loans are from $1,000 to $10,000 and are secured by mortgage with the interest rate charges being based on adjusted family income.

Older persons in Newfoundland can receive assistance with housing repairs through a number of available sources. The Community Development Program of the Department of Social Services can assist qualifying seniors, aged 60 years and over, by providing the cost of labour with the seniors supplying the material. In the case of designated native communities, the cost of materials may be provided by the Department of Rural, Agricultural and Northern Development.

(iii) Federal and Provincial Energy Conservation

The federal government through the Department of Energy, Mines and Resources operates two programs designed to reduce the cost of energy used in the home. These are (i) the Canadian Home Insulation Program, and (ii) Canadian Oil Substitution Program, which provides financial assistance for the conversion of the heating unit in the home from oil to some other form of energy, such as electricity, gas, wood or solar energy. The programs offer taxable grants of up to $500 for the insulation of homes built prior to January 1, 1981, and up to $800 for the conversion from oil, providing the home was heated with oil prior to October 28, 1980. The programs are extended to multi-unit residences and to apartment buildings. These programs are of general application, but also benefit elderly persons who own their homes by reducing their costs of heating.

The Province of Nova Scotia among other provinces has a home insulation program which, subject to certain eligibility requirements, provides low interest rate loans to provincial residents to improve the energy saving capacity of residential housing units. Loans of up to $2,500 are made for insulation and weather proofing and up to $3,000 for approved supplementary heating units. The loans are repaid over five years.

THE CURRENT SITUATION - TRANSPORTATION AND THE AGING

For most of the urban aging population low-cost, accessible urban transport is necessary to carry out normal living activities. For the rural aged, transportation problems may be more difficult to solve owing to lack of public transit systems and because as age advances it may be more difficult for older people to drive their own cars.

Transportation that is responsive to the daily needs of the aged comes under provincial/territorial and municipal jurisdiction. Most provincial and territorial governments, and many municipal governments as well, provide subsidized transportation programs of various types for both the well and handicapped aged. Long distance carriers - bus, rail, air and water - operated under provincial government auspices and/or by federal Crown Corporations, together with a variety of commercial carriers, provide reductions in fares to senior citizens. The Appendix shows a listing of Provincial/Territorial Governmental Programs and Systems, 1982.

A PERSPECTIVE ON THE HOUSING/ENVIRONMENT ISSUES

The desire for a responsible adulthood does not end at a specific age regardless of how old this may be. Aged Canadians prefer to provide for their own comfort, security, and happiness within the limits of health and financial resources. The humanitarian issues surrounding shelter and environment focus on matters that may hinder the aging in pursuing active, independent lives.

Housing Issues

(i) Affordability

One major impediment to the attainment of the above goals is the affordability of shelter, rented or owned, and in particular, rising energy costs as a component of shelter costs. Data from the 1978 Family Expenditure Survey show that energy costs represent 50 per cent of the average shelter payment of elderly owners, with the balance divided between property taxes and repair and maintenance expenditures. Energy cost increases over the past few years have outstripped the indexing adjustment of public sector pension plans which comprise the bulk of the income of most of the aging. This affects the affordability of all day-to-day activities of the aging.

Because shelter affordability problems among Canada's elderly households have a much higher incidence among those who rent their accommodation, and because of the growing tendency for heating and other energy costs to be paid directly by such tenants, the severity of this problem tends to be growing among renters. The thrust of most programs designed to reduce the cost of energy used by households has been towards homeowners. It may be necessary to direct more attention towards elderly renters if the current and future energy cost problems of all of the aging are to be reduced significantly.

In Toronto and other large metropolitan centres, elderly homeowners have expressed major concern about rising property taxes resulting from market value assessment. While assessments based on the current value of the property are not annually adjusted in most provinces, the exceptions being New Brunswick and Quebec, the adjustments, when made, frequently more than outpace the inflationary spiral. The problem has been aggravated by the so-called "whitepainting" or renovation of neighbourhoods, especially in city centre areas, as well as by the enhanced attractiveness of such areas in terms of commuting costs. It arises less as a result of the deterioration of neighbourhoods that are biased in favour of the aged and more because of the property tax system. Most provinces have attempted to reduce the effect of rising property taxes by offering property tax credits, grants or deferral programs, all of which help shelter households from assessment practices. Municipal decision makers attempting to supplement these efforts frequently find that such action would lead to major cash flow problems. Some communities can discount a deferred payment and borrow now to repay in future; most cannot. Renters also face property tax problems. In at least one major city, proposals to better the property tax position of its aging population fell through on the question of how to assist renters.

There are different ways in which elderly homeowners can use their home to supplement income while continuing to live there. For example, part of the home could be converted into rental accommodation. The equity in a home could also be converted into a means of providing income through reverse mortgage instruments.

Reverse mortgages are of two types: (i) the straight reverse mortgage, also called the periodic payment or rising debt model (RDM); and (ii) the reverse annuity model (RAM), which combines the reverse mortgage with a life annuity. While neither are as widespread in Canada as in Europe, for example, if these instruments are to become widely available government initiatives may be required to overcome the major impediments which discourage participation by lenders and elderly homeowners.

The RDM is a pure debt instrument. The lender agrees to make a monthly payment to the homeowner for the term set out in the contract. These payments accumulate as a mortgage against the home, but the interest and the principal of this loan are not payable until the end of the contract. The homeowner must then either sell his property and repay the lender, or renew the contract. Renewal may be impossible if the house has gone down in value or if it has not appreciated significantly.

Because the payments which the lender makes to the homeowner are essentially a loan, they are not considered "income" for the purpose of the Income Tax Act. Thus, the homeowner's tax liability is not affected, nor is eligibility for income-tested benefits such as GIS or provincial top-up programs jeopardized.

The situation is quite different for the homeowner who combines a reverse mortgage with a life annuity. Under the RAM, the homeowner obtains a mortgage loan from the lender for some portion of the value of his home equity and uses the loan to purchase a life annuity. A monthly payment is received from the annuity, but a pay-out of the monthly interest charges on the mortgage loan is also made. (The principal of the loan is not repayable until the annuity contract expires.) Thus, the level of benefits under this plan is lower than the RDM because of two features: the requirement to make a monthly interest payment; and the life-time aspect of the annuity.

The homeowner who uses a RAM will find that his/her tax status has changed. Under this model the monies the homeowner receives are from the annuity, not the mortgage loan, and thus are considered "income" under current tax legislation. The homeowner with a RAM will find that his or her tax liability has increased and that any payments from an income-tested benefit have been reduced, if not eliminated.

If reverse mortgages were to be encouraged as a means whereby the aged could supplement their incomes, it can be anticipated that governments would want to study the appropriateness of making modifications to the current tax treatment of income and interest payments under the RAM model. In any event, governments may want to assume an advisory role and provide the public with information as to how the instruments operate and what rates are currently being offered by various lending institutions. There is no doubt that adequate consumer protection clauses need to be built into each reverse mortgage contract, for the aged are generally seen as a group that is susceptible to questionable marketing practices. Reverse mortgages appear to offer a possible mechanism to assist the aged, both in keeping their homes and improving their financial status.

(ii) Provision of Suitable Housing

The design of living arrangements can enhance or frustrate the pursuit of an active, independent life among the aged, directly or indirectly. Poor design features of homes or apartments can effectively transform a minor functional loss - of strength, or eyesight, or hearing, for example - into a functional incapacity leading to dependency upon others or upon social services.

In projects built specifically for the aged attention is generally paid to design features suited to them, e.g., easily grasped door knobs, colour contrast for eye impairments or orientation, and lower shelving in kitchens. Yet in many projects not specifically designed for the aged, little consideration is given to the design features which can prolong more independent living of older persons. This is despite the fact that many of these design features would be suitable for all age groups and that a growing proportion of housing will be for elderly persons. The aged may also find their own homes can become less suited to their needs, yet a few modifications would permit them to extend the time they can live in them. Up to now few programs in Canada have allowed such modifications though consideration could be given to this method of extending the independence of the aged.

As age advances, more services may be required. Two types may be needed - personal care services related to the individual such as meals-on-wheels and home care, and services related to the tasks of daily living, including cleaning services or repair and maintenance of the dwelling. These services can be provided to people continuing to live in their homes as a means of reducing the need for institutional care. Alternatively, they can be provided in special facilities for the aged. Both approaches have merit and the aged should be able to choose between them, according to their needs.

Older persons often have limited housing options. A broader range of choices should be provided, such as smaller housing within their neighbourhoods, ownership projects where maintenance is provided, and congregate living with, or retirement communities composed of, their peers.

(iii) Unmet Housing Needs

In recent decades, surveys have indicated a strong preference for separate dwelling quarters by older families and non-family persons. This preference is reflected in a significant rise in the population household heads in the older population. It results partly from the improved supply of housing units that have been built, many with the infusion of public funds - federal, provincial and municipal - as well as from a significant rise in disposable money income in the senior citizen population.

Barring a decline in the real incomes of older persons, it has been postulated that their requirements for dwelling units will rise even more rapidly than the growth rate of the population aged 65 and over. The population growth rate between 1976 and 2001 is expected to be about 76 per cent; the number of households headed by senior citizens is projected to increase by about 92 per cent in the same period. With some unmet need for private household dwelling units among older persons living in group quarters, as non-family relatives of a private household head, or in multiple-family households, a further addition to the projected 92 per cent increase is possible.

The current unmet need for housing for the aged is a matter of speculation. Contributing to the uncertainty is the proportion that should be applied to older persons who are members of secondary families, are other non-family relatives of the household head, or are in group quarters who would occupy separate units if they were available - the same problem that affects the future projection noted earlier. A second area of great importance regarding unmet housing needs relates to housing services, the volume of which in the older population is also a matter of speculation. Data to permit an adequate assessment of recent patterns of need for housing services, or of the consumption of such services in households occupied by, or headed by, older persons are very deficient. Notwithstanding the present shortcomings in information, a difficulty that represents a major issue to be addressed, there is no question that a variety of housing for the aged is needed. It should respond to health and income needs and provide a choice of living arrangements. It should include sales and rental housing, new and rehabilitated housing, and large and small concentrations of housing. It should be produced by public agencies and by profit and non-profit sponsors, with incentives to encourage such housing in all communities.

The population aging is indicative of the need to plan for the housing that will be needed in the coming years. Part of the lead time could be usefully devoted to acquiring the kinds of information required in order to effect affordable, appropriately located, and suitably designed accommodation to serve the greatest number of aging Canadians in the years to come.

(iv) Age Integration Versus Age Segregation

Age segregation is an issue that has special relevance to housing for the aged. For those older persons who enjoy incomes that permit a large measure of choice without undue constraint, the matter is not affordability but availability of the housing desired, including whether it is age-integrated or age-segregated. When public housing to meet the needs of the less affluent is involved, developmental issues arise which are both social and political. Thus age integration versus age segregation is a subject considered in the social and political sections.

Transportation Issues

Meeting the transportation needs of the aging is a matter of vital concern. Like all others in society, they are dependent upon the ability to travel and have access to appropriate transportation if they are to acquire the basic essentials such as food, clothing, and shelter, as well as employment and health care. When older people are deprived of necessary transportation, their full participation in the life of the community is denied. It is essential that in establishing and operating transportation systems and services, the needs of all older people be taken into account, including those of cultural and minority groups.

Lack of transportation itself is the problem for many older persons; for others the problem arises because of lack of money for transit fares, lack of available services to places they want and need to go, lack of a transportation system whose design and service features meet their needs, or a combination thereof. The problems interact and thus further increase the transportation difficulties of the aged.

(i) Affordability and Availability

Apart from some concessions in terms of some types of fares, with those of municipal bus systems affecting the greatest number of older persons, transit costs remain a major barrier for many. Costs of transportation have risen rapidly over the past few years and will continue to do so for the foreseeable future. The lower fares offered to the aged have been welcome, but have had to be increased as transit fares for others have increased. Those with limited financial resources continue, therefore, to find the costs of transportation a barrier preventing the fulfilment of their lives in the community.

Services of many municipal systems are, at best, minimal. Suburban elderly dwellers often have to take a taxi to reach the nearest bus stop. This, and a dependency on relatives and friends to get about, limit their use of such systems. While "Dial-a-Bus" and small-scale parallel transit systems have developed, they have not had consistent and stable funding. Some, indeed, have required assistance by charitable organizations to stay operational.

The transportation difficulties of the rural aged are in some ways even more acute than their urban counterparts. They are more isolated, less politically visible, and may have lower incomes although their living costs are usually less. Generally speaking the rural aged have no public transit available to them.

Transportation needs to become a higher priority issue. All the best social and health services in the world are of no use to the aged if they are unable to get to them or the services cannot be delivered where they live. The public and private sectors, working together, will need to consider the ways whereby public transit systems can be developed to meet more adequately the needs of an aging population.

(ii) Design, Service, and Safety of Transportation Systems

Many challenges related to the design, service and safety elements of the transportation systems will be presented to those in the public and private sectors, as well as to individuals, as the population ages. They are as wide ranging as from the design and safety features of the actual equipment to the design and safety features of the systems, and from safe and efficient traffic flow to the education of older persons about traffic safety.

The provision of priority seating and grab bars on buses and subway cars are measures of assistance to the aged and the handicapped. In the case of the former, the problem is one of enforcement so that the use of designated seats by those most in need is assured. When crowded conditions occur on a vehicle, the aged may have to stand; their sense of balance is not as sure as that of younger persons. Getting on and off buses can be very difficult for many older persons as well as for small children and those with infants.

Waiting at unsheltered transit stops can pose a health hazard in winter for older persons. Snow drifts and ice at bus stops and street crossings can prevent access to, and egress from, a vehicle or a street, not to mention the hazards that snow and ice can represent for the aged pedestrian.

Aged persons make up a disproportionate number of pedestrian fatalities. They are often harmed at crossings where turning on a red light is legal because many auto drivers pay no attention to the pedestrians' rights with the green light. The aged are frequently not fast enough to cross streets with cross-lights, especially in winter snow-and-ice conditions. Because engineering for auto traffic has, in the age of the automobile, come to be regarded as paramount, less concern has been given to the pedestrian. The smooth flow of auto traffic should pose a pedestrian hazard to no one.

Transportation represents a major humanitarian issue. When an adequate system is lacking, measures taken elsewhere in education, culture, recreation, health, housing - the spectrum of social needs - can be doomed. Without transportation, the best efforts to participate can fail. Inadequate transportation constricts the life and lifestyle of the aged, limits their ability to be independent, restricts their contacts and opportunities for active interaction with society, and in so doing, adds to their isolation and alienation from society. Affordability, availability, and the design, service and safety aspects of transportation will require early attention if the aged are to have unencumbered opportunities to participate in society.

THE FAMILY

INTRODUCTION

The humanitarian issues discussed in other sections all include aspects that impinge upon the family. For example, the supporting role of the family in care giving is dealt with in the sections on health and on social welfare; the family and its relationship to income security is included in that section. Since the intent is to avoid duplication in so far as possible, the present section will focus upon matters that characterize those units and their extensions that make up "the family".

Programs and services have been designed to meet the needs of aging individuals; rarely are they specific to the family. Further, despite the emphasis given to the importance of the family in providing care and support to its aging members, there is a notable lack of information enabling a definitive assessment as to how this is achieved. For example, although studies have shown that there is frequent contact between at least one adult child and the aged parent(s), they fail to provide information about the total family picture, including the number of other adult children who have infrequent contact with their parent(s) and whether or not this has implications for the parent(s) and the adult children themselves.

Many factors have brought about changes in the traditional concept of the family including a decline in multigenerational living arrangements, partly as a result of smaller family dwellings and partly because the aged increasingly tend to exercise their desire for independence; the mobility of people; and the number of older persons living to the late later years who survive their offspring. In spite of these, all evidence suggests that although there are real problems associated with advancing age, and shifts in family relationships occur, "in times of crisis, people of all ages, young and old, tend to turn for help in the direction of what is regarded as one of life's constants, the bond of kinship".

If the number of persons aged 65 and over in Canada who live in a "family" setting is any criterion, then according to unpublished data from the 1976 Census of Canada, the aged family remains an important component in society. Just over 66 per cent of those 65 and over shared a dwelling with at least one person related by blood, marriage, or adoption (the so-called "economic family"); almost four per cent shared a household with non-related persons; and finally, almost 22 per cent lived alone in their own household, while the remainder lived in some form of "collective housing"*.

Unfortunately statistical data of this kind do not reflect the relationships within the families. Rather than improving with age, interpersonal relationships tend to become entrenched. Those that have been satisfactory become more so; poor relationships can deteriorate even further. Personality characteristics tend to persist. If close ties with children have never been developed, they are unlikely to develop in the later years. Although older people are often actively involved in giving and receiving emotional support through a broad network of kin, meeting the emotional and social needs of aging parents can generate more discomfort and guilt feelings among adult children and family members than is the case with the physical or financial needs.

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* For Census of Canada purposes, "collective housing" is defined as a dwelling of an institutional, commercial, or communal nature, e.g., nursing homes, homes for the aged, hospitals, rooming houses with 10 or more people, and the like.

A PERSPECTIVE ON THE AGING AND THE FAMILY

A prevading myth, which is not supported by the evidence, is that older people in modern society are abandoned by their families. Its perpetuation results from a number of factors including:

(a) geographic mobility;

(b) economic and other circumstances as major determinants of whether or not older persons continue to live in their own households;

(c) the disproportionately large segment of the institutionalized aged who are alone, without children or kin;

(d) the increasing number of four, and even five generations in families; and

(e) the increasing numbers of women who work outside the home.

Despite the geographic mobility of people in industrialized societies, contact between the generations is maintained by letters, telephone, and visits. Most older persons prefer to live in the community that has become familiar to them, or in a new community of their own choosing, than to follow their children as they move about to fulfil the requirements of their own lives.

As government pensions to the aged began to improve in the early 1960's, many who previously were unable to exercise their preference to live in their own household found that they now could. Since 1966, when the Old Age Security and Guaranteed Income Supplement payments increased more substantially, the Canada and Quebec Pension Plans were introduced, and provincial, municipal, and private sector assistance programs and subsidies became more prevalent, the trend has accelerated. The proportion of women aged 65 and over living alone almost doubled between 1961 and 1976 rising from 15 to 29 per cent. Although the rate for aged men living on their own increased from 10 to 12 per cent during the same period, it was low by comparison; lower life expectancy and the tendency of widowers to remarry are the main reasons.

Improved health in the older population has made it easier to undertake housekeeping chores and thus makes living alone more feasible and attractive. It has also become more socially acceptable over the past two decades. The increased supply of housing suitable for persons who live alone has been another factor influencing its popularity.

Aged women predominate among those not living with a spouse but with children or other relatives. There was an estimated 200,000 such women in 1978. Over 70 per cent of them would have fallen below Statistics Canada's low-income lines if they had tried to live independently. This low-income group was made up of 12 per cent who were living in family units that were already classified below the line; an additional 58 per cent would join them and become "poor" if all of them moved from the household they shared with children or other relatives. The conclusions are based on the assumption that independent living would be in the same locality where they had been living, and personal incomes would have remained the same.* Although not documented, it is known that the limited incomes available to many of these women, as well as their less numerous male counterparts, provided a regular source of financial assistance to the families of which they were a component and who, in their turn, provided care to their aged relatives. This in part refutes charges that families are breaking down, are unwilling to help each other, and are non-caring.

A high proportion of older persons living in institutions are aged 80 and over, never married, or the lone survivor of a childless marriage. Another group in institutions is there because of a phenomenon that has become increasingly apparent over the past two decades, namely, that the group aged 65 and over is comprised of two generations. It is estimated that one in 10 persons aged 65 and over has a child who is in this same broad group; hence the two generations - one, 65 to 74 , the other 75 and over. Those in the younger age group, the so-called "young-olds", may have chronic ailments and disabilities of their own; they want to have some of their aspirations for retirement fulfilled. The inability to provide physical care for an aged parent does not mean that there is a lack of caring; emotional support is the sustaining bond.

Middle-aged couples in increasing numbers have as many as two sets of parents and four sets of grandparents, all in the so-called "senior years". These middle-aged couples may, or may not, have brothers, sisters, or other relatives with whom responsibilities for meeting the day-to-day care and support needs of aged parents and relatives can be shared. Further, they usually have children, and even grandchildren, of their own who present conflicting demands and competing interests with those of aged kin; they have their own retirement to prepare for, and, as they themselves grow older, they may be starting to experience some of the decrements of the aging process. The women, many of whom have remained at home to raise their own families, may in middle age have to choose between caring for an aged parent or relative and seeking employment outside the home in order to improve the family's economic situation, build an equity in a pension for themselves, and/or satisfy some of their own personal goals.

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* Source: Unpublished data, Statistics Canada, Survey of Consumer Finance, 1978.

Family Patterns

(i) Older Couples

Many older couples are able to maintain considerable independence, even in the face of infirmities, by reallocating chores and nursing each other.

There is available evidence to support the benefits of marriage in the later years, as well as the importance of the husband and wife roles as significant components of adulthood. Even so, a marriage relationship is not equally available to both sexes in the later years. In 1976, for the total group aged 65 and over, about 74 per cent of men were married compared to 39 per cent of women. A comparison of the differential between the groups aged 65 to 69 and aged 80 and over is very revealing - over 82 per cent of men and 56 per cent of women in the former group were married; just over 53 per cent of men in the latter group were still married but only 14.5 per cent of the women. The situation arises because of three factors: men tend to marry women two to 10 years younger than themselves; life expectancy at birth favours women by seven years and at age 65 by slightly over four years; and older women marry and remarry less readily than older men.

Only 20 per cent of the male population aged 65 and over was widowed in 1961; by 1976 it had declined to just over 15 per cent. On the other hand, widows in the same age group have continued to predominate in the older female population; they made up almost one half of it in 1976.

The impact of the marriage pattern of the past 40 years on the future female population can be seen in Table 9. It shows the female population aged 65 and over by marital status from 1975 to the year 2000; the widowed population is also shown by 10-year age groups. Table 10 shows the relative variation of each marital status population during this same period. It can be seen from this table that while the total female population 65 and over will increase by 79 per cent between the years 1975 and 2000, the increase of the single (never married) population will amount to only 26 per cent. This reduction is due to new generations with a low proportion of those never married reaching age 65 and replacing previous generations which had a high proportion of those never married.

The combined effect among future generations reaching age 65 of a lower proportion of single (never married) persons and a smaller age difference between spouses, explains the disproportionate growth of the married female population which will occur between 1975 and the year 2000 (105 per cent as compared to 79 per cent for the total female population). This phenomenon will be largely restricted to the population 65-74 years old. It will, however, also occur for the widowed population in the aged 65-74 group. In this group there will be a 36 per cent growth between 1975 and the year 2000. In the case of the widowed population aged 75 and over, the increase will approximate 100 per cent.

Table 9

Projection of the Total Female Population Aged 65 and Over by Marital Status and for the Widowed by 10-Year Age Groups

Year	Marital Status ('000)						Grand Total**
			Widowed				
	Total Single	Total Married*	65-74	75-84	85+	Total	
1975	113	434	250	211	80	541	1,089
1980	125	517	293	248	88	629	1,271
1985	133	601	322	289	102	713	1,446
1990	138	718	346	340	120	807	1,663
1995	142	814	360	374	140	874	1,830
2000	143	889	339	408	166	913	1,944

* Includes divorced and separated.

** Sub-totals may not add to grand totals due to rounding.

Source: Unpublished data prepared by Long Range Planning Directorate, Policy Research and Long Range Planning Branch (Welfare), Department of National Health and Welfare, 1976.

Table 10

Relative Growth of the Total Female Population Aged 65 and Over by Marital Status and for the Widowed by 10-Year Age Groups, Taking 1975 as 100, Canada, 1975-2000

Year	Marital Status						Grand Total
			Widowed				
	Total Single	Total Married*	65-74	75-84	85+	Total	
1975	100	100	100	100	100	100	100
1980	111	119	117	117	111	116	117
1985	118	138	129	137	128	132	133
1990	122	165	139	161	151	149	153
1995	126	188	144	177	176	162	168
2000	126	205	136	193	208	169	179

* Includes divorced and separated.

Source: Unpublished data prepared by Long Range Planning Directorate, Policy Research and Long Range Planning Branch (Welfare), Department of National Health and Welfare, 1976.

That there will be a continuing need to support various forms of family relationships appears evident. Unfortunately little has been documented about the specifics of kin relationships of older persons who live with children or other relatives. Some unpublished data from the 1971 Census of Canada for the Province of Alberta do, however, reveal that over one quarter (27 per cent) of widowers, and 30 per cent of widows in that province in both the 65 to 74 and the 75 and over age groups, share housing with children (single or married) and/or other relatives. Widowed men and women appear equally likely to share housing with single children - nine per cent in the case of those aged 65 to 74; and from six to seven per cent of those aged 75 and over. Thus for whatever the reasons, obligations whether filial or familial are still respected.

(ii) Cohabitation

Cohabitation arrangements, which have not been legally defined, have been entered into by some older persons due to economic necessity. The combination of Old Age Security (OAS) and the full Guaranteed Income Supplement (GIS) for a single person (widowed, never married, or divorced) is greater than one half of the amount of OAS and the full GIS for each of a married couple. It is therefore economically advantageous for those wishing to share their living arrangements to retain their single status.

(iii) Substitute Families

In 1976, 11 per cent of those aged 65 and over in Canada lived in substitute families; in some cases all, or some of those with whom they lived were related by blood, marriage or adoption; in others, none in the group was related. An example of the former is the adult foster home where one or more non-related elderly persons live with an "economic family" - usually a nuclear family composed of the parents and their own progeny. Substitute families may, or may not, be multigenerational. Such arrangements may result because of financial need, the need for care or companionship, or some combination thereof. They can be rewarding in the opportunities they afford for mutual sharing.

(iv) Surrogate Families

The surrogate family is a type of substitute family. Its establishment is usually the result of deliberate action taken to accomplish a specific goal, for example, a young family who "adopts" a non-related older person as a surrogate grandparent to live in their home.

Families of Original Peoples

(i) Native Indians

Until very recently few Native Indians were to be found in institutions for the aged because the extended family was the rule rather than the exception. This is in direct contrast to non-Native households where the nuclear family predominates.

The advantages of the extended family to Native Indians were numerous: married couples had greater mobility because of the presence of grandparents willing and able to care for, and instruct, the children; pressure was taken off domestic situations and allowed greater scope within the marriage; the elders benefited from having a respected and necessary function within the family unit, and a source of interest and inspiration in their old age; and the grandchildren benefited from having an added dimension to their care and instruction, as well as a direct link with the history and traditions of their people.

This family situation still predominates on rural reserves and in isolated settlements. Examples set by the so-called "media families" (television, movies, and the like), and the insistence of housing authorities on the "one-family dwelling" have, however, somewhat eroded the extended family even in some areas that are more rural than urban.

In cities, where the majority of Native Indians live in apartments, the extended family has suffered severe setbacks. The most obvious victims of these are the old. Perceiving themselves to be either a hindrance or unwanted, they tend to live alone in poor conditions with inadequate food and other necessities. Most are either too proud or afraid to be part of an "old folks' home".

By not having their elderly members in the immediate family, other generations lose as well. The advantages listed earlier are removed. Without the mobility and safety value provided by the extended family arrangement, the pressures of urban life often result in child abuse, violence, desertion, and other expressions of frustration. Young people lose the continuity which assures them of their place in the generations; they are deprived of the knowledge of their language, history, and culture which they might otherwise have had.

There has been an assumption that the impact of change and urbanization that has affected Native Indians is felt mostly by the young. It now seems that this is not true; the effects of change are as great for the aged as for everyone else.

(ii) Inuit (in the past referred to as Eskimo)

The Inuit represent an unique culture not only in Canada, but in the world. While the material aspects of this culture have changed significantly over the past two generations, the Inuit retain their essential links to the family and the land. As with any culture that relies upon the verbal transmission of knowledge, the elderly Inuit play a key role in maintaining this culture and its associated economy. Western society has a great deal to learn from a culture that places a high value on the participation by the aged in the family and the larger community. It is in these spheres that they retain their sense of worth and their identity as productive and active members of Inuit society.

The elderly Inuit retain a direct and intimate knowledge of the land and its resources - a knowledge obtained over a lifetime of living in a rigorous and often harsh environment. At a time in the history of the

Inuit society when the traditional values are being renewed, the knowledge and skills of grandparents have never been more important.

As opposed to most other societies, the Inuit world is in some ways placing a greater value on the role of its aged than was the case in earlier times. It is through them that the culture and society will remain self-sustaining.

Multicultural Families

(i) Ethnic Groups

Aged persons in ethnic groups whose mother tongue is neither English nor French, and who have not mastered either, tend to feel alienated in terms of language and culture. Too often communication with grandchildren is limited because they have not learned the language of the grandparents Families experience difficulty in getting services to help their aged members. This is partly due to the language barrier, and partly because the services may be at variance with the patterns in the ethnic culture from which the older person has come. It may not be possible for smaller or newly arrived ethnic groups themselves to provide the kinds of programs and services needed, whether community or institutional; the small number of the aged to be served may be the economic justification that prohibits government funding.

There are ethnic communities which have retained such a cohesive family and neighbour network that their aged members do not have to rely upon outside services. Further, older established ethnic groups with sufficient elderly persons to warrant them have developed many programs, often with the assistance of government funding.

(ii) Immigrants and Refugees

To a large extent, Canada's immigration policy is family centred. Thus young immigrants and refugees can sponsor their older family members. These aged persons remain closely associated with their families. They may, however, be ineligible for, or lack access to, services that are generally speaking available to other older persons. Finding ways to enable the provision of health and social services, as well as income support, to older immigrants and refugees will ease their integration into Canadian society.

A PERSPECTIVE ON FAMILY ISSUES

Independence and Interdependence

The desire to remain independent is very strong in older people. Dependency is feared; they may associate it with becoming a burden on their families or having to be placed in institutional care. The concept of dependency is, however, often confused with the "need to have someone to depend on", namely, interdependence. In the case of older persons this need should be regarded as "normal dependency" and a right of the aged. Security is the central focus in satisfying this need.

Older people continue to do as other people do and as they have always done. They continue to be social beings, and social interchange remains an integral part of their daily lives. The real difference lies in their ability to carry out all their daily activities easily under their own power. The scope and variety of activities may be suddenly and drastically altered by physical changes. Thus the distinctive feature of the social functioning of older people is its tendency to break down or fail, partially or wholly. The point at which this may occur is as yet fairly unpredictable.

An important factor in providing older persons with a sense of security is knowledge that dependable 24-hour "on call" help or protection is available. The sense of security this creates markedly reduces the necessity for its use, for example, housing developments to allow for independent living of older people with immediately available on-site help or electric emergency call systems to summon off-site help. Easy access to a range of community services such as home help, visiting nurse, meal-on-wheels, health care, and the like also helps to provide a feeling of security. This sense of security is something apart from dependency. It is the "sense of independence" desired by all of us that is based on the certainty that protection is available in time of need. It is the kind of feeling that competent and immediately available fire and police protection in a community gives - the kind of security that does not rob one of independence.

The dominant family form in Western cultures is said to be the "modified extended family", that is, a nuclear family connected with, and aided by, an extended family network. This arrangement allows for "intimacy at a distance", as the preferred relationship has been called.

Family Support of the Aged

Financial support of the aged no longer rests solely with younger family members. It is now accomplished by way of societal mechanisms, such as the income security programs, which provide for at least the basic needs regardless of the closeness of family ties. Emotional ties have displaced economic bonds as the currency upon which family members trade in exchanges with one another.

There is considerable evidence to suggest that aged couples, and those who live alone or with relatives other than their spouse, probably receive many of the necessary kinds of informal support from the members of their extended families. Others have no support network either because they have no relatives or have only maintained tenuous ties with them. But when they do not live in a family situation or sufficiently close by to allow for ready access to help and support, the ability of the family to meet, or continue to meet, the needs of an older family member may be restricted.

There are forces at work that will effectively ensure that the family in its traditional concept will not be the "be-all-and-end-all" in the care of the aged. The declining number of descendants is occurring at the same time as the surer survival and lengthening life span of aged parents and relatives. Kin resources become over extended in the day-to-day care of aging relations. Other obligations and constraints compete with duties towards elderly family members.

The limitations of the family support system are producing service industries and professional workers to provide community, home, and institutional care. To deny that future demands on these developments will not greatly increase is to deny the facts of an aging population.

There is, however, an option which might offer encouragement to families to overcome the obstacles to home care thus initiating some reduction in the demands on the formal support system. Tax concessions and/or special allowances to family care givers could preserve and promote the kin ties so threatened by demographic change. Further, if unrelated older persons, lacking kin support, turn increasingly to their peers and establish substitute families to the extent that they involve a significant number of the aging, the pressures on formal support organizations could be greatly reduced. Although the extension of financial incentives, similar to those that might be offered to families caring for relatives, could be highly influential in the establishment of substitute families, their growth and effectiveness in providing an informal support system will depend upon the extent to which cultural values and laws change so that a more hospitable climate is created for them.

It should be noted that income tax provisions currently permit single persons (never married, widowed, or divorced) to claim a tax deduction, up to a maximum limit, for the care of an infirm older relative who is dependent. With the door already opened to allow a measure of reimbursement for the care of relatives, the rising costs of care provided through the formal support system may tend to encourage broadening and extending the arrangements.

There are community support programs that aid both the aged living alone and in families. They include day care programs, day and night hospitals, meal programs, special transportation services, and the like. Respite care deserves special mention because it is specifically designed to serve families caring for older adults. Although none of these services has been established to the extent needed, evidence suggests that they, as well as organized home care services, are being organized across the country. They can be very effective in strengthening the informal support networks, helping both older people living alone and families caring for aged relatives.

Family Law and the Aged

With a few notable exceptions, such as the amount of the Guaranteed Income Supplement paid to couples as opposed to single persons (widowed, never married, or divorced), and the requirement that the spouse of a recipient aged 60-64 in receipt of the Spouse's Allowance must be an Old Age Security pensioner, there are no laws in Canada specific to the aged family. All provinces, however, have legislation, rarely enforced, requiring children to provide support for dependent parents, based on a needs and means test.

Laws such as those affecting marriage and its dissolution, property ownership, and the sharing of pension credits under the Canada and Quebec Pension Plans upon the dissolution of a marriage, affect those of all adult age groups. It is the application of the laws in respect of married women that creates serious problems, particularly those laws concerning marital (matrimonial) property.

Marital Property

Every province has legislation which establishes the full legal right of a married woman to own property and enter into contracts independently of her husband. In 1970, Quebec enacted the first legislation in Canada to provide for the equal division of property acquired during a marriage when the marriage is dissolved.

The Canadian Advisory Council on the Status of Women and the women's advocacy movement in Canada have proposed that upon marriage dissolution, the principle of the equal division of marital assets be universal, and apply to all present as well as future relationships (including common law consensual relationships).

Property acquisition rights have always been important to older persons, particularly aging women. Since the federal Divorce Act, 1968, established that a three-year separation period was sufficient to constitute marriage breakdown, thereby extending the grounds for marriage dissolution, divorces among aging couples have increased. Census of Canada data show that in the case of men aged 65 and over divorces increased by just over 3,900 between 1971 (7,160) and 1976 (11,085); the increase for women in the same age group was just over 4,400 - 1971 (7,140), 1976 (11,580). The degree of equity reached in the division of the marital assets is unknown.

SOCIAL WELFARE

INTRODUCTION

"Social welfare" is most simply defined as the well-being of people. It implies the inclusion of various aspects of life such as economic, health, social, recreation and education. "Welfare", in its most limited sense, has been viewed as public assistance; most often associated with economic need.

Social services can be described as:

> "those organized activities and provisions that have as their basic purpose the enhancement of individual and collective abilities to lead socially useful, satisfying and independent lives. They include the more specific objectives of prevention of conditions that cause disadvantage or disability; rehabilitation to bring individuals, families and groups to a higher level of participation in social and economic life; protection of those whose safety and well-being are at risk; and development of individual, group and community capacities for growth, enrichment and social participation.
>
> "Social services are facilitative in nature, that is, they encourage self-determination by the users and the joint participation of providers and those who make use of the services. They require the contribution of a variety of social service personnel from different disciplines, volunteers, self-help and both the formal and informal support networks within the community."*

A brief reference to the social services system will help to situate the social services within it. The "system" is larger than the social service programs delivered by provincial departments of social services and social development. It includes programs provided by municipal governments, non-governmental voluntary agencies, and citizens, consumers, and other special interest groups. Several social service programs delivered directly by the federal government must also be included.

Since the scope of social services is broad and diverse, social service functions have been infused into a wide variety of institutional arrangements. Social service programs and planning activities can be found in the fields of health, education, public housing, manpower development, social assistance, corrections, justice, vocational rehabilitation, and recreation. Thus, broadly defined, social services encompass the above fields, as well as several others including various counselling programs, rehabilitation, family and child welfare services, and local development programs.

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* Report of the Working Party on Social Services to the Continuing Committee on Social Security, Interim Report on Social Services in Canada, Federal-Provincial Social Security Review, Ottawa, October 1974 (Unpublished).

Considering social services as just one part of a larger network of human services provides a clearer focus. The relationship turns on such practical questions as whether mental health and programs for the retarded belong in departments of social services or departments of health, and whether ancillary health benefits for social assistance recipients are a health matter, an income maintenance question, or a problem in social services. There is no "correct" answer to these questions. It is clear, however, that the social services system cannot contain within one jurisdiction all programs that at a given time, or according to a particular definition, may be considered broadly as social services. Social services do, however, appear to be mandated to identify gaps in other systems and respond to needs that are unmet by them.

Identifying social services as a system necessitates that they be visualized as part of a constellation of services that are present in any society. Social services and these other services are interrelated, interdependent, and sometimes overlapping.

"Social welfare" is listed as a separate humanitarian issue along with such others as income security, health, housing, employment, and education. This section will therefore be confined to those areas that by custom and tradition have been included among the "social needs of the aged", and will deal with those programs that have been developed within the social services system to meet them.

A PERSPECTIVE ON THE SOCIAL ASPECTS OF AGING

Generally speaking, older persons have the capacity to lead independent and useful lives, enriched by a lifetime of experience. As a group, however, they encounter great obstacles to the satisfaction of these needs - sharply reduced incomes, unsuitable living arrangements, ill health, physical handicaps, loss of family and friends, isolation from community affairs, and loneliness.

Some are able to avoid, and some others are able to overcome these difficulties alone or with family help. For many, however, the removal or management of these obstacles can be achieved only in part by individual effort. For example, recovery from a disabling handicap depends upon individual will plus many medical and social skills which can only be provided by community action. Nearly all the usual as well as the unusual problems encountered in aging call for a greater or lesser degree of external help.

To assist older persons to attain satisfying standards of life and health while at the same time helping them develop their full capacities in personal and social relationships, a flexibly organized system of social services is required. These services include those organized and practical activities which conserve, protect, and improve human resources.

Sympathetic and skilled social casework is often required to help those who are sick, disabled, or experiencing declining physical capacity. It is often possible for them to continue to live in their own homes only with special household helps and aids or with protective services when mental functioning is impaired. Handicaps can often be overcome in protective living conditions and through rehabilitation, both social and medical.

When disability becomes too severe, alternative living arrangements may have to be made, but choices should not be arbitrary ones. Individuals should have the opportunity to weigh the advantages and disadvantages of living with relatives, in private family living (foster care), or moving to a home for the aged or nursing home. Whatever the choice, the guiding factors should be the well-being of the older person and of his/her family.

Aging people, as a group, are vulnerable to the loss of social supports. Friends move away or die; the aged often outlive their families, or must continue to live far away from relatives; associations built up at work are lost in retirement. These circumstances frequently lead to isolation and loneliness, which in turn may adversely affect personality and health. Personal counselling, community and senior centres, friendly visiting, community services, and sheltered employment make opportunities available for continuing constructive and meaningful activity.

These social services can add up to a practical expression of older people's independence. Unfortunately the social arrangements are often not well enough adapted to make the later years the social and personal assets that they could be. Difficulties may stem from several factors. First, the needed service may not be available, or access to it may be denied because transportation is lacking or architectural barriers impede its use. A second factor may be that the older person does not know that the service required is available. Language and cultural differences may inhibit an older person from seeking the help needed. Finally, without encouragement and emotional support, there may be an absence of either the energy, will, or both to look for a service or to use it.

The family is a primary resource in assisting older persons in adapting and adjusting to the process of aging because of the continued and often enhanced importance of family ties and responsibilities to older individuals. Changes in modern life have, however, created difficulties for them and their families as they try to maintain ties and responsibility, and strengthen bonds between the old, the middle-aged, and the young of today's extended family. A distinctive attribute of social services for older persons should be the focus on the family.

The aim of the social services is to provide the facilities and programs that older people can use when required. The services are designed to:

(a) help older persons continue to live in their own homes for as long as possible;

(b) provide care and protection away from home when that becomes necessary;

(c) help families make workable plans which satisfy the requirements of both the family and the aged person, especially when physical or mental health is involved;

(d) contribute inter-disciplinary teams that provide professional services and skills;

(e) help provide opportunities for older people to use their experience and knowledge in planning, and their skills in useful activities; and

(f) help adults prepare wisely for their later years.

Conditions which threaten to undermine independence can often be prevented, or their effects minimized. It pays to give early attention to the small symptoms of social and personal maladjustment or ill health in order to avoid or delay the onset of more crippling conditions. Independent living increasingly depends upon the community resources upon which individuals and families can draw. If these resources are inadequate, then personal and family difficulties, illness, loss of income, and fear about the future take their toll in the breakdown in personal relationships and premature disability.

A variety of social services have been developed to help the aged but they are unevenly distributed. Some cities have some services but not others. Rural areas and small towns labour under special disadvantages because of fewer organizations and services, and less economic resources, although volunteer help by neighbours may be more available.

Broadly speaking, some 60 per cent of the aged function independently of any special need for social and/or health services. Concern for this group centres on the lack of programs for the prevention of social and/or health breakdown. About 20 per cent of older persons require periodic supportive services; the remaining 20 per cent constitute the "at risk" group, largely to be found among those 80 and over. They require a range of comprehensive services and assured continuity of delivery. But if the well-being of the aged is to be the goal, all those 65 and over must be kept in mind in developing social services for older people.

Several types of services function to support the objectives identified in the definition of social services. Some are concerned with income support, employment, and the like. For the purposes of the present section, the types involved are:

(a) informing, linking, and referring mechanisms that join people with services and thereby assist them in meeting individual and community needs (e.g., information and referral centres, crisis centres, advice clinics, storefront offices);

(b) services that facilitate and support the involvement and participation of people in their communities and in society (e.g., community development, social action, advocacy, social planning);

(c) services that assist disadvantaged groups such as the disabled, handicapped, and the aged to live as normally and independently as possible, as well as those services that prevent the need for institutional care or provide alternatives to it (e.g., home care, respite care, counselling, meals-on-wheels, adult day care, private family living, drop-in and activity centres, sheltered workshops, etc.);

(d) services that support children and families (e.g., prevention, protection, adult day care, private family living, home care, homemaker or home help services, respite care, nutrition and family counselling, legal aid, etc.); and

(e) services that provide alternative environments for those unable to remain at home in their own community (e.g., homes for the aged, nursing homes).

The functions described by this classification and the specific services implied by the functions are not mutually exclusive. Adult day care, for example, can be viewed as a family support, as a method of enhancing or maintaining employability and thus providing income support, or as a community support service for the aged.

Comparing the four objectives of prevention, rehabilitation, protection, and development with the types of classification of social services produces some interesting relationships. For example, services that facilitate and support the involvement and participation of people in their communities and society are largely preventive in nature. Services that provide alternative environments for those unable to live at home are primarily protective. But a social service may serve more than one of the objectives. A service that is primarily protective in nature may also have preventive, rehabilitative and developmental aspects. For this reason, it is useful to consider the four objectives as integral and overlapping parts of a continuum, with the specific goals of a particular service being modified according to the circumstances at hand.

Although presently services of a protective and rehabilitative nature receive greater emphasis, as part of a continuum, none has greater value than the other; all are of equal importance. While preventive services may lessen future need for rehabilitative and protective services, these latter will always be required. Some social problems and conditions of the aged cannot be entirely prevented. Likewise, the presence of a full range of preventive, rehabilitative and protective services would not lessen the need for development services.

THE CURRENT SITUATION

Jurisdictional responsibility for the provision of social services is, like the health services, largely provincial. Federal involvement in their development has basically been in the commitment to funding social services directed to those persons who currently are, or potentially may be, in financial need.

Federal Programs

Although the Canada Assistance Plan (CAP), administered by the Department of National Health and Welfare, is not specific to the aged, it is of great importance to thousands of them. Through it the provinces are reimbursed for one half of the costs of assistance to persons in need, or to those for whom the service is essential if they are to remain self-supporting. In terms of older persons, assistance costs shared under the plan may include any form of aid to meet the cost of: basic requirements such as food, shelter and clothing; items of special need of any kind; travel and transportation; funerals and burials; clothing and comfort allowances for residents of institutions; as well as certain health services and institutional care in a home for the aged or a nursing home not covered under the block funding arrangements mentioned in the section on health. Welfare services under the plan, which could benefit older persons, include rehabilitation services, casework, counselling and assessment, homemaker (home help) services, and the like.

Some New Horizons projects, funded by the Department of National Health and Welfare and described in the section on education, culture, and recreation, have provided social services such as meals-on-wheels, telephone checking and reassurance, and various types of an informational nature. Community projects, as a part of job creation endeavours, including those for summer students, have been funded by the Canada Employment and Immigration Commission. They frequently serve the aged, for example, home help, home repair and maintenance, meals-on-wheels, arts and crafts instruction, reading to the blind, and the organization of drop-in centres.

The Department of Veterans Affairs introduced the Aging Veterans Program in April 1981. Its purpose is to help older veterans maintain their independence and continue to live in their own homes and neighbourhoods. Besides required health services, the program aims to provide home maintenance such as housekeeping and groundskeeping, home modification, meals-on-wheels, day hospital or adult day care, and nursing home care in the veteran's community. Local resources and services will be utilized and the veterans will be helped to obtain them.

Provincial Programs

Provincial and territorial social services vary across the country. The specific programs offered within each jurisdiction are outlined in the Appendix - Provincial/Territorial Governmental Programs and Systems, 1982. Although it is not the purpose of this report to deal with programs provided by non-governmental bodies, many of them are funded in whole or in part by governments. For example, CAP and provincial government funds help to maintain a majority of the aged who are in institutions operated under both governmental and non-governmental auspices; senior centres may receive substantial funding from provincial and municipal governments and/or through the New Horizons program. If, on the other hand, a classification is undertaken according to the primary agent of delivery, the social services fall into three broad groups:

(a) Provincial programs which include those services that are designed and delivered directly by provincial departments of social services and related departments, such as health, education, labour, manpower, and cultural affairs;

(b) Regional and municipal programs which include those services that are delivered by regional or municipal governments, usually under the aegis of provincial departments of social services. In some provinces regional and/or municipal involvement in social services is quite limited; in others the traditional municipal role is fulfilled through community boards;

(c) Voluntary and community programs which include all those non-governmental services provided by the traditional voluntary agencies as well as services offered by community, citizens', and consumer groups.

Home Care and Home Support Services

(i) British Columbia

The Ministry of Health through its Long-Term Care and Home Care Programs provides most of the home care services in the province. Homemaker services to both families in crisis and retarded adults living in the community are provided by the Ministry of Human Resources.

The Long-Term Care Program encompasses both home and institutional care. The assessment of the individual's social needs and care requirements; homemaker, handyman, and meal services; adult day care centres, geriatric assessment and treatment centres, and residential care from the personal care to the extended care levels are all included within the program's orbit. The Home Care Program, on the other hand, was established to serve two categories of patients - non-hospital replacement, and hospital replacement. The first is for those needing care by a physician and at least one other professional service such as nursing or physiotherapy; they may also require homemaker (home help), equipment loan arrangements, and the like. The second category served includes those discharged early from an acute care hospital, or those placed on home care in lieu of admission to an acute care hospital. The chief characteristics of the majority of these patients are that they are acutely ill, need at least one professional service, and may require extensive, frequent services over a short period of time.

(ii) Alberta

The Department of Social Services and Community Health sponsors the Co-ordinated Home Care (CHC) program, and through its Family and Community Support Services (FCSS), funds homemaker services provided by many local FCSS boards. Twenty-six local health authorities provide the services of the CHC program. The services may include some or all of: home nursing; homemaker, home help, and handyman; physical, speech, occupational and respiratory therapies; transportation; meals-on-wheels; and friendly visiting. A small adult day care program in Edmonton serves disabled persons.

(iii) Saskatchewan

In northern Saskatchewan, home care services are provided as part of the Services to the Elderly Program of the Department of Northern Saskatchewan. In the southern part of the province, all 45 district home care boards responsible for the delivery of services offered by the Home Care Program, sponsored by the Department of Social Services, will be in operation in 1982. Nursing, homemaker (home help), meal service, and home maintenance comprise the mandatory services. Boards can provide optional services, within the limits of available funding, once the primary services are available throughout the entire district. Optional services include physiotherapy, social work, occupational therapy, nutrition counselling, chiropody, and laundry service.

(iv) Manitoba

Planning, co-ordinated program direction, resource allocation, and service delivery are the home care responsibilities of the Department of Health. Service delivery is accomplished through regional offices, health centres, and home care offices located in the Winnipeg hospitals. Included in the services available are health care (professional nursing; licensed practical nursing; physical, occupational, and speech therapies), homemaking and household maintenance, personal care, respite care through services placed in the home or through temporary care in personal care homes and many hospitals, adult day care in over 30 personal care homes located throughout the province, supplies and equipment, and volunteer services. In Winnipeg, the Victorian Order of Nurses administers the short-term home care program.

(v) Ontario

A two-component Home Care Program is sponsored by the Ministry of Health - acute care and chronic care. The former is available province-wide through 38 local boards of health or other approved agencies such as the Victorian Order of Nurses. The latter, first introduced on a pilot basis and slowly extended, is expected to be province-wide in 1982 at which time the two components will be amalgamated. Services include nursing; physical, occupational, and speech therapies; homemaker (home help); social work services; nutrition counselling; drugs, dressings, and medical supplies; diagnostic and laboratory services; hospital and sick room equipment; transportation; and meals-on-wheels.

A Home Support Program for the Elderly, sponsored by the Ministry of Community and Social Services, is operated by the social service agencies of local municipalities, townships, and Native Indian bands. No services are mandatory; homemaking, meals-on-wheels and home maintenance are the ones most commonly provided. To those requiring less than three visits per month, nursing services are offered.

(vi) Quebec

Home care is sponsored by the Ministry of Social Affairs. It delegates responsibility to the regional health and social service councils for the organization of home care, the identification of service agencies, and the co-ordination of services in their respective areas. Precedence must be given to local community service centres (CLSC) where they exist. The CLSCs are directly responsible for delivering home care services of a general nature; other health and social service organizations can be called upon as needed for more specialized services. The staffs of the CLSCs may include physicians, nurses, nurses aids, social workers, and homemakers (home helps); providing home delivered services is part of their responsibilities.

(vii) New Brunswick

A Home Care Program, operated by the Department of Health, is available throughout most of the province. It has two components: a short-term program available to the total population, and a long-term program which is exclusive to those aged 65 and over. Nursing, physiotherapy, nutrition counselling, medical supplies and sick room equipment are included in the services provided. The Community Services for Seniors Program of the Department of Social Services provides the aged with services which complement those delivered by home care. These include counselling, respite care, homemaking, heavy housecleaning, handyman, adult day care, protective oversight, meals-on-wheels, and friendly visiting.

The Extra-Mural Hospital Program which began operation in October 1981 on a pilot basis, is ultimately expected to serve the total population. Under the general supervision of a physician, it will offer treatment, rehabilitation, nursing care, the provision of necessary equipment, and counselling to patients in their own homes. It will be co-ordinated with other services; patients can be referred to other services by the program. Admission and discharge will be as in traditional hospitals. The Extra-Mural Hospital Program will in time replace both the short-and long-term programs mentioned earlier.

(viii) Nova Scotia

The Department of Social Services administers a province-wide homemakers services program established by legislation under the Homemakers Services Act and Regulations. Services provided include: meal preparation; light housekeeping; personal care and hygiene; and assistance with shopping, banking, and in keeping medical appointments.

In August 1981, the Senior Citizens' Secretariat, through the Departments of Social Services and of Health, embarked upon pilot home care projects for a trial period of one year in two counties. Services offered include both nursing and homemaker. It is expected that the pilot projects will lead to the development of a province-wide comprehensive home care program.

(ix) Prince Edward Island

The Department of Health and Social Services administers a visiting homemaker (home help) service and the Home Care Program. The latter provides nursing care, as well as orderly service for male patients as required. The provision of physical, occupational and speech therapies is largely confined to a consultation service for the nurses. The nurses arrange for nutrition counselling as needed, and for homemaker service from the department's Social Services Branch. Hospital equipment is available on loan through the Red Cross; dressings through the Cancer Society.

(x) Newfoundland

Besides a well-established Home Care Program in St. John's, funded by the Department of Health, home care services are provided in five other regions in the province. A co-ordinator, usually hospital based, generally assumes responsibility for these services which are dependent upon regional resources. The St. John's program provides nursing, social work, physiotherapy, and homemaking services as well as medications and medical supplies. The Red Cross provides equipment on a loan basis. A homemaker (home help) service provides help to persons of all ages in their homes; special attention is given to the aged. This service is available in various areas of the province through the Department of Social Services homemakers' staff. The Department of Social Services provides funds for items of special need not ordinarily covered by other departments, e.g., plumbing in rural areas for incapacitated aged persons.

(xi) Northwest Territories

A Co-ordinated Home Care Program, operated by the Departments of Health and of Social Services is available in Yellowknife, Hay River and Fort Smith. Besides nursing and homemaking services, professional services carried out by a physician, dietition, physiotherapist, occupational therapist, speech therapist, social worker, psychiatrist and mental health nurse are available; meals-on-wheels, equipment, and neighbourhood services such as handyman, friendly visiting, transportation, and errand service complete the list.

(xii) Yukon Territory

No home care program is available.

Senior Centres

Senior centres have been developed in every province and in the Yukon Territory. Their characteristics vary widely; their location may be rural or urban. Some function as drop-in centres, some as activity centres, and still others as multi-purpose centres for older persons. They may or may not have professional staff; their hours of operation vary. The number of senior centres in each jurisdiction differs in proportion to the voluntary and self-help interest displayed in communities, and according to the amount governments and communities use them as a mechanism for the delivery of services to the aged. Ontario is the only province with specific legislation for senior centres - the Elderly Persons' Social and Recreational Centres Act, 1962; replaced in 1966 by the Elderly Persons Centres Act which was proclaimed in February 1968.

Increasingly multi-purpose senior centres are becoming focal points for community social services to the aged. Not only do they offer a wide range of recreation and educational activities in which older persons can participate, they also provide services of various kinds. Some, such as legal aid, help with forms and financial accounting procedures, health counselling, a housing registry, and information and referral are available on-site; others may be outreach programs such as volunteer visiting, meals-on-wheels, sharing experiences with children in schools, and protective oversight for the frail aged in their homes. Many of the services are undertaken by centre members themselves; others by professional staff. For example, in Quebec, the aged are supplied with appropriate medical and social services at "les centres du jour". In addition to providing a variety of services at one location, some centres extend such services as meals-on-wheels, home nursing visits, home help, counselling, and other health and social services into the community.

Adult Day Care

Some provinces have instituted adult day care for older persons although in no province is it universally available. It is designed to provide socializing opportunities and relief to families. Adult day care may be established in multi-purpose senior centres, in institutional settings, or as a special program designed to provide only adult day care services. In addition to the day care concept for social services, there are also "day hospitals" which provide not only health related services, but counselling, recreation and social opportunities on a daily admission basis. The latter are noted in the section on health.

Some Other Services

Private family living (terms such as foster home and boarding home are also used) arrangements have been available through some provincial governmental programs for many years. There are different interpretations regarding the concept including the maximum number of the aged to be cared for in each setting. In Newfoundland, older persons discharged from mental hospitals have been cared for in licensed boarding homes for many years. The foster care program for aged persons in the Regional Municipality of Niagara, Ontario is well known; as in Newfoundland, several persons are cared for within one family setting.

Although interest in this type of care has been growing, it does not represent a major category of care. In Manitoba, however, foster care may be part of its Continuing Care (Home Care) Program, or arranged through other social service programs and funded by social allowances as with other age groups. In Quebec, over one quarter of the adults placed in foster homes (familles d'accueil) are aged persons.

Respite care to allow families rest or vacation time away from caring for aged family members is receiving increasing emphasis. To date this form of care is mainly available in the larger population centres in the provinces. Generally speaking it has been provided in an institutional setting, but it may also be offered in the person's own home or in a substitute home living arrangement.

Older adults are providing counselling services to their peers in some provinces through programs organized and funded by a provincial department of government. For example, the Volunteer Senior Citizen Counsellors Service in British Columbia was established in 1968 by the Department of Human Resources. Counsellors, aged 65 or over, are of mixed ethnic backgrounds. The service is available throughout the province with counsellors serving as a resource in their own communities to aid the aged who need help. This ranges from assistance with forms and documents to locating living accommodation, and from accompanying older persons to medical appointments to friendly visiting. In Ontario, the Senior

Volunteers in Service Program of the Ministry of Community and Social Services generally speaking serves the aged in smaller communities. Retired persons aged 55 or over who live in the community commit themselves to the program to assist the aged who need Ministry programs and services, to act as sources of information to elderly persons in the community, and to speak on their behalf.

Institutional Care

In the section on health, some of the difficulties associated with determining the percentage of the population living in institutional arrangements, for Canada as a whole and by province and territory, were mentioned. Terminology relating to institutional facilities also varies, for example, a home for the aged may be called a lodge; a nursing home (for the aged) may be called a private hospital. Further, some institutions offer only board and room, whereas others provide extensive personal and/or health care services. For the purposes of this report, institutions for the care of the aged, other than general and allied special hospitals, will be termed "homes for special care".

Institutional care is available in all provinces and territories; it may be provided under provincial, regional, municipal, voluntary or commercial auspices. Homes for special care are required to meet standards set out in provincial legislation respecting them, as well as those related to health and safety standards applicable in other legislation. Homes under voluntary and commercial auspices are usually provincially inspected. In some provinces they must be licensed.

All provinces make special grants towards the construction or renovation of homes for special care by regional or municipal governments as well as voluntary organizations. Generally speaking, such institutions are exempt from municipal taxation. Further, it should be noted that Canada Mortgage and Housing Corporation, under the provisions of the National Housing Act, between 1947 and 1980 loaned or insured loans to aid in the construction of 46,000 beds for the aged in homes for special care (called hostel beds in the Act). Provincial participation with the federal government in the cost arrangements are outlined in the section dealing with housing and environment. It can be seen in Table 11, however, that these beds represent less than one third of the total rated beds serving the aged in 1980. At that time, there were almost 66 rated beds per 1,000 population aged 65 and over in Canada; there is a wide variation in the rated beds between the provinces and territories.

Table 11

Rated Beds in Homes for Special Care (Homes for the Aged and Nursing Homes) by Province and Territory Related to the Population Aged 65 and Over, 1980*

Provinces	Homes for the Aged	Nursing Homes	Total Beds Related to Those Aged 65+	Rated Beds per 1,000 Population Aged 65+
Newfoundland	1707	30	1737	42.2
Prince Edward Island	721	547	1268	88.7
Nova Scotia	4817	1558	6375	72.5
New Brunswick	2358	2104	4462	66.9
Quebec	27366	5542	32908	62.2
Ontario	27950	27179	55129	67.8
Manitoba	2822	4006	6828	59.1
Saskatchewan	4824	2412	7236	65.4
Alberta	5429	6797	12226	79.6
British Columbia	13483	3117	16600	61.4
Northwest Territories	18	34	52	34.7
Yukon Territory	77	-	77	110.0
Canada	91572	53326	144898	65.7

* Sources: Information Systems Directorate, Policy, Planning and Information Branch, Health and Welfare Canada, Statistical Information on Homes for Special Care, March 31, 1980, and Statistics Canada, Population Estimates June 1, 1979 (Unpublished).

Many services including nursing; counselling; social work; physical, occupational and speech therapies; transportation; and volunteer services, provided under the home care and home support programs are also required by those in institutional care. The interrelationship between the home and the institutional environments is further demonstrated by the fact that the institutions themselves may provide focal points for the provision of services to persons living in their own homes. As noted earlier they may offer adult day and/or respite care. Some provide activity centres attended by older persons from the surrounding community. Residents of some institutions have organized a telephone checking service in order to monitor the daily well-being of their peers who live alone in the community. Many homes for special care prepare meals for the meals-on-wheels programs; some offer their dining facilities in order to provide hot meals on a regular basis to the aged living in the community - a so-called wheels-to-meals or lunch club arrangement. Living in an institution is no barrier to many of the residents who are regular participants in senior centres in the community. Increasingly two-way communication and activities between the community and institutions for the care of older people are being strengthened.

A PERSPECTIVE ON THE SOCIAL ISSUES

Implications of the Objective of Social Services

The broad objective expressing the purpose of the social services for the aged is:

> To enhance the quality of life by:
>
> (a) developing a dynamic community responsive to the needs of the aged;
>
> (b) ensuring the opportunity for older persons to assume responsibilities, exercise rights and choices, and participate in community life; and
>
> (c) preventing, and where necessary removing, social conditions that adversely affect individuals, families and communities;
>
> so that older people may develop a sense of worth, fulfilment and self-determination.

Quality of life represents the desire of all people to achieve a state of personal well-being that is rooted in, but goes beyond, immediate social and economic roles. It includes the very basic aspects of everyday living - relationships with family, peers and community, leisure and recreation activities, and the like. To ignore these aspects of life is to fail to deal with the whole person.

Quality of life is increasingly seen as the goal of all members of society, and is thus a concern of social services related to the aged. As people become less concerned with day-to-day subsistence, and the focus of social services becomes broader to include more aspects of human life, the quality of life can be expected to take on a greater emphasis as the guiding objective of the social services system.

The development of a "dynamic community responsive to the needs of the aged" implies more than a merely reactive response by the social services to existing conditions. To accomplish this requires that social services go beyond the "presenting problem" to address the causes of that problem. A dynamic community capable of change, capable of adapting its institutions to meet new needs, is an important objective for the social services system. Equally, if not more important, is the quality of every community's concern for its aged citizens who require help. Attainment of a dynamic and responsive community is itself a developmental process that can only take place through increased involvement in, and awareness of, the social conditions of older people and the social services they require.

In conjunction with the legal and other systems, social services play an important role in encouraging the fulfilment of personal responsibilities. They also assist in the exercise and protection of rights, particularly for certain broad population groups such as children, the aged, the poor, and the handicapped.

Participation in community life is an increasing interest of many older Canadians and the social services system is playing a complex and still emerging role in facilitating their involvement. Participation is sought for a variety of reasons. Chief among these is the speed with which social change and economic development are taking place and the unforeseen consequences of these activities. The pace of change has set a high premium on planning, particularly at the local level, and older people are beginning to reach out to be involved in these activities. At the same time, local communities have, over the recent past, become more active in defining social and economic needs and in taking action to meet these.

All of these developments present a challenge to the social services; a challenge that is obviously multifaceted and may be responded to in a number of ways. Exercise of rights and participation in community life are closely linked. But individuals of any age, as well as local communities, often find it difficult to approach governments and non-governmental bodies. Social services are playing an increasing role in this area by helping to facilitate the identification of problems at the local level and by helping to mobilize people, including the aged, to define, develop, and obtain solutions to these problems. In the years ahead the social services system could become even more important in aiding older people to realize this objective.

A wide range of specific services that are traditional elements of the social services system is involved in the prevention, alleviation, and removal of adverse social conditions. Many problems require the particular intervention of social services which offer a variety of specific responses. The types of services that may be called upon to address adverse social conditions include the provision of alternative care facilities or situations for those aged persons who require special environments, and the provision of support services to those who require help to enable them to overcome personal difficulties and participate more fully in the life of their communities. In general then, alleviating and removing adverse conditions require that older people have access to, and information about, a wide range of social resources. The social system is the primary means of both developing and operating this range of resources.

The emphasis that governments might give to "preventing, alleviating and removing" adverse social conditions deserves special mention. A standard criticism of existing social programs is that they are primarily reactive; that they address existing problems of the aged instead of trying to prevent them before they occur. All governments agree that more attention should be devoted to prevention as a general objective, but they also recognize that impediments to accomplishment are many. To aid in their intent to find ways to be more responsive in the prevention of adverse conditions, they are expanding their efforts in the analysis of social indicators and trends.

The third part of the objective for the social services system emphasizes the role of social services in monitoring and assessing social conditions, and identifying those interventions appropriate for their improvement. Governments might, therefore, tend to consider that in those aspects of planning that bear specifically on social matters, the social services system might play an active and leading role in identifying problems and developing alternative responses. Provincial departments of government responsible for social services have demonstrated their willingness to contribute positively to this process, and where necessary, lead in the development of local, regional, and urban planning, co-ordinating and integrating mechanisms.

It is important at this point to stress that in emphasizing that a recognition be given to the development of social services for the aged as an integral and dynamic part of society, there is no intent to support the existence of social services for their own sake. Further, care is needed to avoid the trap of viewing social services as capable of righting all the wrongs or solving all the problems of the aged in society. The justification of social services for the aged should be based on the analysis of individual and societal needs and the ability of services to address those needs. This is a responsibility shared by all people involved in the system. Governments have a critical role in this; at all levels they are showing their willingness to assume it.

A planned structure of services that has built-in mechanisms for continuity, and provides for a continuum of care, is required if the social needs of the aged are to be met. Issues to be addressed need to be considered in the context of policy development out of which evolve the appropriate strategies that result in action.

Community Care in Relation to Institutional Care

Viewing community services as an alternative support system to institutional care implies that a clear choice is available. The implication is that both are available. For many of the aged no real choice exists; there may be only minimal domiciliary support in their own home. The issue to be resolved is that of social equity for the individual. It involves the allocation of resources to the different systems and the delivery of services on an integrated and comprehensive basis. Doubtless governments, non-governmental agencies, and society in general will be grappling with this issue for some time to come.

If community care of the aged is to become the preferred mode of support for the majority, the imbalance between expenditures related to homes for special care and those related to home care and support programs will require a measure of redress. For example, in 1978-79 provincial expenditures on homes for special care for adults, of which those serving older people form the largest part, were roughly estimated at about $920 million; by 1980-81 the federal government alone, through the Extended Health Care Services Program, was contributing over $700 million to the provinces, most of which was attributable to institutional care. By contrast, expenditures on home care and home support services were just over $100 million in 1978-79. Although these figures are only approximate, they do provide some idea of the disparity in the financial commitment to the two forms of care. This is not to say that a difference will not continue to exist, it is to suggest that there may be a need to consider a greater financial commitment to home care if its full potential is to be realized.

Other issues that will command attention regarding home care and home support services include:

(a) entitlement criteria respecting various services; aspects to consider will involve access to the services (i.e., whether availability will be on demand as a result of self-assessment by the older person and/or his/her family, or only upon professional referral), and whether the service will be available to all the aged or only to certain targeted groups such as those on low incomes;

(b) user charges; and

(c) standards regarding each type of service.

All of these issues will need to be taken into account, but given the phenomenon of an aging population, it may be useful to consider moving beyond restrictive conditions of eligibility where supportive services such as homemaker (home help), heavy cleaning, handyman, and even meals-on-wheels, particularly during the winter, are involved. This preventive approach could be justified from two aspects: the aged tend to understate their needs rather than overstate them, and earlier provision of help may prevent the later unavoidable resort to more expensive services.

Provision Compared to Need for Services

The relationship between service provision and need reflects a concern to be addressed. In some locations where large numbers of the aged live, needs are not being met; relatively high utilization rates for services in other areas, where the number of aged persons is small, suggest that provision may not have been based on needs criteria. This seeming failure to match provision and need even at the aggregate level raises concern about the capacity of services as presently organized to support aged individuals in the community. Part of the problem may be due to lack of a detailed assessment of disability and need, even though such an assessment is a prerequisite basic in planning a program of action and the services needed to implement it. Another aspect may arise because the provision of a particular service obtained may have occurred because the local agency or group, with which the first contact happened to be made, offered that service and once started it may continue, barring regular review. Since inappropriate services may even increase dependency, those providing care need to assume responsibility for monitoring the person's condition, co-ordinating services received, adjusting supports as required, and referring the aged person to other services as necessary. A well-developed mechanism which allows persons to be referred and transferred as required is a feature of an integrated service system.

Guardianship, Protection, and Legal Aid

Some form of protection is needed for older persons who are unable to handle their own affairs or who may be exploited by others. Certain legislation, such as the Old Age Security Act, has provision for trusteeship related to the specific income referred to in the legislation; the Department of Veterans Affairs has the power to administer the War

Veteran's Allowance when necessary, but cannot assume responsibilities beyond the allowance itself. In some provinces guardianship can be obtained by application to the courts but this can be a lengthy and costly procedure.

The issue to be resolved involves the rights of the aged individual. The first responsibility is, therefore, the protection of those rights and absolute dedication to the well-being of the older person. Legislative action would be required to establish the arrangement. Management of the estate should be included. The New Brunswick Child and Family Services and Family Relations Act, 1980, which came into force in September 1981, is the only legislation in Canada that provides the comprehensive protection that seems to be required. The matter assumes increasing importance with the aging of the population; as does the need for legal aid and legal counselling, both frequently needed by elderly persons who cannot afford to pay for such professional services.

Crime against the aged - abuse, fraud, assault, robbery, and the like - is occurring more often and is more frequently reported in today's society. Departments of Justice and police forces, at all jurisdictional levels, are engaged in programs to alert older people regarding the dangers and suggest ways to enable them to protect themselves. This is a concern in which the aged can, and should, become directly involved with their peers, communities, and the law enforcement bodies.

Informational and Related Services

Expanding services for the aged, coupled with the increased demand for information about them and about aging in general, has raised the demand for information dissemination, means by which clients can be referred to services, crisis intervention, client advocacy, and follow-up of inquiries and complaints. The development of community information centres throughout Canada has been one response to this problem. Their development and effectiveness have, however, been hampered by a number of unresolved issues including the lack of stable funding mechanisms to ensure continuity; staffing, training, and supervision of personnel; and the development of standards to ensure the reliability of information, and the confidentiality, efficiency, continuity and accountability of the services.

A sophisticated network of social services is of little use if information does not reach the potential users. Social services for the aged have been separated from income assistance programs. New entry points to the social services per se, and information programs are thus becoming more critical. In the future, community information centres may become an ever more important means of identifying those who need social services.

Public and Voluntary Sectors

The relationship between the public and voluntary sectors in the delivery of social services is not a new issue. Voluntary organizations have a long history of heavy involvement in the delivery of social services; their contribution is well recognized. But increased public and consumer expectations of the social services, and particularly those concerned with the aged, disabled and handicapped, competition for scarce operating dollars, concerns about duplication and fragmentation of programs, and the like have brought the matter into prominence again.

To gain a perspective on how the voluntary sector is involved in the delivery of social services, it is useful to detail the principal methods through which this involvement takes place. Many voluntary agencies provide personal social services to clients of all income groups, receiving subsidies from provincial or local levels of government for those clients who meet financial assistance criteria. Others provide services to more specific population groups, defined on the basis of income, nature of need, or ethnic origin. The methods of government financing are equally diverse. Purchase of service is used in numerous circumstances by governments, but particularly where the clients served qualify for cost-sharing purposes under the Canada Assistance Plan. In some cases, governments subsidize the individual client or client family income so that they may purchase the service directly from the agency. Other methods of financing include the subsidization of agency budgets through annual sustaining grants or deficit financing arrangements.

It is not the purpose of this report to engage in a detailed analysis of what specific role the voluntary sector or portions of it should play in the delivery of individual social services. Whatever the role should be, it should be decided in conjunction with each provincial government, having regard for such factors as the relative strength and capacity of the voluntary sector, the degree of overlap among voluntary agencies and between voluntary agencies and public services, and provincial priorities.

Today, when reference is made to voluntary agencies, it is normally understood that these are established non-profit organizations having an administrative structure independent of government and accountable to a board composed largely of private citizens, funded at least in part by voluntary donations and usually incorporated. The "established" voluntary agency should be distinguished from the relatively recent phenomenon of self-help, citizens', and community groups that have surfaced in most provinces. Over time, many of these groups become part of the "established" voluntary sector and are followed by the rise of other innovative services. The emergence of groups, under many different auspices, offering various kinds of services or programs to the aged has been in evidence in many communities in recent years. Some are composed solely of the aged themselves, some of children, young people, or adults of all ages. Considering the aging of the population, they have special significance; they also introduce elements for consideration by provincial and local governments. Among these are the competition for financial resources, and finding the most appropriate ways to fit them into the social service network.

Participation by the Aged

Regardless of sponsor, a wide array of opportunities for participation by older people could be offered through the social services. To date, however, neither governments nor voluntary organizations have been particularly successful in achieving this. Increasing demands for participation are not viewed with enthusiasm for reasons that include: the process is often clumsy and time consuming; participation by "non-experts" will not necessarily yield better decisions; and few people have the desire, coupled with the will, to participate even in those decisions that directly affect them.

Positive aspects that bear consideration regarding the participation by the aged in the decisions of major institutions in society need to be emphasized. First is that reluctance to participate may be due more to a lack of knowledge about bureaucratic decision making, and a lack of resources with which to become involved, than to a lack of interest. Participation in a process is difficult when there is no knowledge that the process is going on. Second, while immediate results may be ambiguous and the process time consuming, participation can do much to avoid unnecessary polarization and confrontation. Third, the involvement of the aged in decisions that affect their lives can do much to increase understanding of public or agency policies and programs, and to mobilize support in their favour. People do identify strongly with programs they have helped to plan. Finally, participation of older people in planning and decision-making processes could result in their further involvement in the actual delivery of services.

It has been demonstrated in Canada that not all public services need to be provided directly by governments; the growing number of volunteers in social service activities attests to the desire of many citizens, including the aged, to contribute to their communities and to society. Participation can thus be an important means of facilitating the use of people's interests and talents in a wide variety of programs. The question with which governments, voluntary organizations, and society must grapple is: How can the doors to opportunity be opened so that the aging can participate more effectively?

EDUCATION/CULTURE/RECREATION

AGING AND RETIREMENT

For the vast majority of Canadians, retirement is a time of options, choice, and freedom. One recent study, Retirement in Canada, showed that 79 to 84 per cent of Canadian retired men and women respectively were finding their post-retirement years satisfying to very satisfying. Even perceived income inadequacy was not a major barrier to satisfaction, for, among those who felt their incomes were inadequate, from 62 to 72 per cent of men and women respectively were satisfied to very satisfied with their retirement. Given the high association and correlation between perceived income inadequacy and reported health inadequacy, such figures imply that most of those who do not enjoy the best of health nonetheless find retirement has its delights. The pleasure that retired Canadians feel in having the time to take up new and rewarding activities is evident in all studies of Canada's retired population.

Certainly, the major lifestyle change that retirement from full-time work brings is not without some adjustment problems. The evidence is, however, that most Canadians make such adjustments by capitalizing on their assets and talents, as well as available opportunities in their communities. Their interest and determination to lead satisfying lives underlie their success in doing so.

There is, however, a group made up of those who are unable or perhaps unwilling to make the transition from the work they have known to retirement. They are dissatisfied. Usually, these are men and women with strong work orientations, who feel that their status and prestige are shaped by work and income, and, who find the loss of work weakens their psychological perception of themselves as responsible, useful and productive members of society. Compared with those who make a successful transition to retirement, as measured by satisfaction, they more frequently report a lessened opportunity to see friends or relatives, develop special interests, choose neighbourhoods, or develop new friendships after retiring.

The data that exist on those unhappy with their retirement have some serious limitations. For instance, they do not show how many people entered a dissatisfied state upon retirement or afterwards. Yet, without dwelling on the matter, some persons were probably dissatisfied with their lives prior to retirement. Further, the data do not tell what constraints actual low income or poor health place on the ability to achieve a measure of satisfactory well-being. Self-perceived income inadequacies and self-perceived ill-health status go hand-in-hand in most research studies, but what is perceived as inadequate by some may often be seen as adequate by others.

Despite these limitations, it is evident from various studies that many of the dissatified, and especially men, have dismaying images of themselves. They show a lessened sense of direction, lower self-esteem, deteriorating health, and declining mental vigour. This minority of retired Canadians is often socially and personally passive, and occasionally alcoholic.

What is most disturbing with respect to men is the incidence of mortality in the immediate post-retirement years. Retirees aged 67, for example, have higher mortality rates than those a year younger or older. The Statistics Canada study, Retirement and Mortality, looking at the male retiree population collecting the Canada Pension Plan (CPP) or the Régime de Rentes du Québec (RRQ) benefits from 1971-74 has commented that "the difference in mortality observed between ages 66 and 67 (among men) reflects ... low mortality in the first year of retirement and elevated mortality during the second year. This higher mortality during the second year could be accounted for by a deferred stress impact, or by the onset of boredom and other correlates of "disenchantment" relatively soon after the "honeymoon" phase. Between ages 68 and 69 mortality in the retiree cohort increases at a greater rate than for the general (male) population."* How much this is a barometer of the stress that some men experience adjusting to retirement from work is open to speculation. But age 67 is the mid-point in what is often regarded as the five years needed to adjust to retirement from the working world.

There is other crude evidence that a significant minority of men face severe adjustments and cannot make them. For instance, although not a leading cause of death, the suicide rate for men in the age 65 to 69 group, in vital statistics for 1977, was about 30 per cent higher than that of the five-year-younger cohort. It represented the highest rate among either males or females in the elderly population. As such, it is considered seriously disquieting.

Relatively speaking, the subject of women and retirement has been neglected by researchers. Data from a few empirical studies regarding the meaningfulness of work and the impact of retirement on women have suggested the importance of work to them. The historically accepted view, namely, that women face less of a dilemma upon retirement because they are relinquishing a secondary role, while men are losing a primary role; that work is not as meaningful to women; and that women are not economic providers nor do they derive self-esteem or identity from work roles, has been challenged by findings in some recent research. But with the increase in the number of women who will be retiring, and with a clear indication that some research findings may be invalid, and that all such findings should be interpreted with caution because too many questions remain to be answered, there is undoubtedly a need to examine the meaning of work for women within the changing social context.

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* Over the period in question, but based on June 1971 census data, the authors of the report suggest that it is only at age 69 that the general male population is clearly comprised of more non-working than working males. This partially reflects their finding that in 1971, males not in receipt of a CPP or RRQ pension were more than twice as likely to be in the labour force than out. They were also more likely to participate at ages 67 and 68.

Despite data problems, it appears fair to say that perceived ill-health and income inadequacy can limit the ability of some of the aging to move about, to socialize, and to participate in community activities. The lack of financial resources to purchase educational and/or recreation offerings of a market economy can affect satisfaction. For still others, the opportunities to participate in community activities are restricted by other factors or they have restricted accessibility to facilities that would enhance their participation. There are, of course, people who are constrained by all of these problems.

In the latter 1970s, one study on social participation of the pre-retired and the retired showed that the pre-retired expected to participate more (than those who were already retired) in travelling, volunteer work, community centre activities, and pursuing special interests or hobbies. Expectations of such participation plummeted, however, for the retiree who had ill health or low income. Further, the retired complained that, despite their lower expectations, lack of access and opportunities resulted in less participation than they had hoped for, particularly among those with physical and/or mental disabilities.

Perceived well-being is a critical element in participation and in what is perceived as participation. Thus, low personal interaction activities, whether inside or outside the home (i.e., from reading a book to attending a theatre) can be immensely satisfying for some; for others, high interaction activities define what they mean by participation in life, i.e., from being active in a sport to being involved in a volunteer activity. No one meaning applies to anyone, much less to that group called the aging who have had 60 or more years of a variety of experiences to discover and create differences among themselves. Life changes and lifestyles vary more among the aged than in any other cohort in society. Withdrawal of some of the aging from activities of all sorts, when considered in light of their views that they are unable to do what they would like to do, suggests that a significant minority of the aged face problems which lead to some involuntary withdrawal from participation in life.

Attempting to address many of the above problems, governments in Canada have attempted and experimented with a variety of programs for, and affecting, the aging.

The following discussion is grouped into two categories: (i) universal programs in the sense that they are non-targeted but of considerable benefit to the aged; (ii) age-oriented services and programs specific to the elderly population.

Universal Programs/Services

The federal Secretary of State Department is involved in many activities of major importance to the well-being and quality of life of Canadian citizens. While none of the activities are age-specific, many have promoted a greater awareness of the social roles and human rights of Canada's aged as well as supported and encouraged their participation in public and community affairs. Through support for official language minority groups, multicultural groups, and Native peoples, the department has assisted people to lobby on issues, to gain access to services (i.e., meals-on-wheels, special housing, or health care), and directly and indirectly fostered the intergenerational dialogue that enhances the role and participation of older people while simultaneously assisting in the preservation of language and culture.

The department is also active in promoting and encouraging physical fitness and recreation among the aging. The department, along with most provincial governments and larger municipalities, funds or otherwise supports and encourages activities that aim to increase the quantity and improve the quality of human and physical resources; to provide recreation opportunities; and, to increase the awareness of the benefits of physical fitness. Often, surveys, research, programs, literature and materials of this department and those of other governments include the older population as a specific group.

Age-Specific Programs

(i) New Horizons

About a third of Canada's aging are presently either directly involved in, or directly served by, the New Horizons program, established in 1972. The program is designed to encourage retired persons to participate in community life; to offer them an opportunity to put their knowledge and experience to work for their own benefit and the benefit of other persons; and, to help them build friendships and mutual support activities.

Program field representatives assist in the development of project groups and ideas and provide or locate other assistance as required. Activities supported by grants include arts and crafts, sports and recreation, preservation and promotion of history and culture, continued education, community services, self-help and skills-exchange programs, formation and strengthening of senior citizen groups, and occasionally, financing social events.

The impact of New Horizons on the development of organizations designed by, staffed by, and servicing the aged has been major. These types of organizations have shown dynamic growth over the decade the program has operated.

(ii) Canadian Executive Service Overseas (CESO)

This non-governmental service provides an opportunity for elderly volunteers to use their training, educational background, experience and skills in projects to assist development in under-developed countries and Native communities. The Canadian International Development Agency, which is responsible for Canada's programs of assistance to under-developed countries, gives an annual grant to CESO to fund foreign projects, while the Department of Indian and Northern Affairs funds the Native projects. Retired persons who serve as volunteers are paid travel costs, maintenance and out-of-pocket expenses. In Native communities, about 3,000 assignments have been undertaken since 1969, and, there are currently about 750 volunteers on roster. Since its establishment in 1967 CESO had, at the end of the 1981-82 fiscal year, completed about 3,000 overseas projects, and now has about 2,700 volunteers on roster. These volunteers are generally in the 60 to 70 year age group. Their role has been and continues to be to provide technical or management guidance and advice, such as feasibility studies, to manage or guide an established operation, and to assist with training.

(iii) Provincial Recreation, Fitness, and Cultural Programs

Most provinces either financially assist or encourage the development of recreation and cultural activities to benefit the aging. The policies are varied, differing from province to province, and range from helping senior centres, directing programs on recreation and culture, counselling aging persons to set up such activities, providing free or subsidized travel tours, providing outdoor holidays, and providing or encouraging the provision of other services to the aged.

Perhaps the most important sources of recreation and cultural activities are senior centres. These range from drop-in centres to multi-purpose centres. A centre may provide only recreation and cultural activities or it can be a centre where a full range of services for elderly persons can be found: recreation, cultural, social services, health care services, counselling, advice, and so on. The facility may be either rented or owned by a voluntary or public body. Most are operated with voluntary help (and boards of management) and are open either full time or part time. These centres may receive operating funds from government, although this varies from province to province.

In addition to recreation and cultural activities available to aging persons in the community, services are also provided in institutions and in public subsidized living units - as well as those residences which provide care in addition to shelter (i.e., chronic care facilities, intermediate care institutions, nursing homes, homes for special care, homes for the aged, sheltered housing, group homes and hostels). If an institution is publicly operated, the recreation or cultural activities it undertakes normally will be publicly financed. In both voluntary and commercially operated institutions, such activities provided are costed into the fee structure which, however, may be subsidized through public funds.

Several provinces have specialized programs for the aging. Alberta promotes the interests of the aging in the theatre. Provincially and municipally, Alberta offers consulting services for the recreation needs of seniors. The province conducts special workshops and classes on fitness, sports and outdoor activity, and reports municipal sponsorship of recreation centres for seniors. The province sponsors an Alberta seniors sport and fitness association and summer games for seniors. Ontario, through Community Information Centres, helps inform elderly persons about the resources available to them. Quebec, through two programs, provides holiday camps for elderly persons and short-term vacations in open-air reception centres, and provides subsidies to special institutions to meet the cultural and recreation needs of seniors. Saskatchewan assists in developing Senior Activity Centres for culture and recreation, provides free access to provincial parks and trans-Canada camp grounds and offers free fishing licenses and reduced rate golfing permits. Saskatchewan, Manitoba and Quebec provide assisted travel tours within their provinces to elderly persons. Within Manitoba, community-based senior citizens' groups are eligible to receive assistance under Multicultural Programs and Human Resource Development Programs aimed at cultural development, improved visibility and sharing of resources. In Nova Scotia, local recreation programs are available throughout the province from municipalities, community groups, and organizations assisted by the province. Programs for seniors include recreation and cultural activities, fitness and exercise classes. Six regional offices in Nova Scotia assist with the development of cultural, recreation, sport and fitness programs in the region, and assist in improving existing buildings as community centres. A regional fitness development program in Nova Scotia helps develop fitness programs, seminars and conferences.

Most provinces provide information on programs and activities and provide direct stimuli for programs and activities providing recreation and cultural activities.

(iv) Lifetime Learning and the Aging

Education is a lifelong process and the need for education does not come to a halt in pre- or post-retirement years. Pre-retirement education about post-retirement life is equally as important as is education in earlier life stages. Similarly, rapid social, economic, cultural and political changes place great emphasis on the role of academic and non-academic education in the post-retirement years, as indeed in the other stages. Pre- and post-retirement education is linked as well with the personal changes and personal growth that can accompany (or be sought for within) the lifestyle changes of later years.

Many Canadian employers, - governments, businesses, and institutions - provide pre-retirement workshops or seminars for their employees. Federal, provincial, and municipal governments, in addition to providing such workshops, have in some cases also recognized the need for pre-retirement counselling. Such counselling and education tend to focus on the problems and prospects of retirement, with emphasis on how to resolve problems and how to plan for a personally satisfying post-retirement life.

Of course, not all employers provide seminars and many employees retire without knowing what the problems may be or some of the mechanisms to cope with them. To assist such workers and their employers, some provinces encourage the provision of pre-retirement workshops, usually by other groups and organizations. Quebec provides such seminars through school commissions, general and vocational colleges (CEGEPs), universities and some local-service community centres (CLSCs). Nova Scotia encourages the presentation of pre-retirement and retirement seminars as part of its continuing educational program for elderly persons. New Brunswick set up a program in April 1981 called Financial Planning, which is a pre-retirement counselling program. It is aimed at younger age groups (20-55) to help them plan for their future. Yet another program in New Brunswick is one on pre-retirement counselling open to all ages but specifically for those five to 10 years from retirement. The program provides information on retirement to groups on request and to the public through continuing education programs. The premise underlying these programs is that proper information and planning begun early in life will help alleviate many potential problems of aging and retirement. District home economists and district agriculturists in Alberta help organize pre-retirement programs in rural areas. The province has also developed four pamphlets and other materials on retirement planning and is encouraging the development of pre-retirement planning programs through its career centres and local councils for continuing education. Saskatchewan, through its Department of Continuing Education, initiated a major project in the area of pre-retirement education in the 1980-81 fiscal year. The project has produced a matrix of major and sub-content areas to be considered when planning pre-retirement programs; video and audio cassettes focussing on health, lifestyles, financial and legal planning for retirement, a comprehensive audio-visual program for creative retirement planning, and other reference materials and guides for pre-retirement planning courses and workshops.

After retirement, the aging frequently seek formal and informal instruction for a host of reasons. Some may wish to train for new skills or hobbies; to improve the management of their financial affairs; to improve their talents and skills; to improve self-care or home health care among family members; to join bridge and other social clubs; or, by challenging their mental and physical abilities, to remain alert. Formally and informally, significant educational opportunities generally exist for the aging. In New Brunswick, a program with both educational and fitness features is somewhat unique. New Brunswick's Université du Troisième Âge operating out of the University of Moncton, provides various education opportunities for seniors in francophone communities, and is presently providing, with provincial funding, an extensive range of physical fitness programs for seniors.

Many universities and community colleges provide courses for the aging. These courses may be academic or non-academic. In the case of the academic courses, these may be audited or taken for credit. Courses are provided free or at a nominal fee. A network of universities and colleges operates programs providing live-in summer educational programs on campuses. It is government policy to underwrite the above programs. Through provincial Departments of Education, all provinces provide opportunities for continuing education to elderly persons. The courses may be regular courses or specially designed for the aging. Some may be taken by correspondence or telephone hook-ups. Several provinces provide mobile library services to the aging, including those in outlying areas. In Saskatchewan, most programs for the aging are through community colleges. Saskatchewan offers special training to library staff so that they can better serve elderly users of library services. In many provinces, public libraries stock large print and talking books for those aged with visual impairments and for others with such problems.

It should also be noted that most provinces underwrite activities that support the use of the aging themselves as information resource persons for other aged persons. Such programs as Seniors Assisting Seniors in Saskatchewan are found under different names across most of Canada; government assistance, financial or otherwise, is often available.

A PERSPECTIVE ON THE ISSUES

The experience of the voluntary sector in Canada has shown that, given opportunities to design, plan, and implement participatory activities, the aging have shown a tremendous willingness and capacity to do so. This suggests that the active involvement and participation of the aging on their own behalf and for others should continue to be encouraged: as activators, partners, implementors, and participants involved at all levels in defining problems, planning strategies, and implementing the development and delivery of services and facilities in the areas of education, culture, and recreation. That they can assist in increasing the educational, recreation, and cultural opportunities of the aging and Canadians overall is a matter that needs better understanding by all persons involved in the design and delivery of programs and services under these auspices.

Access and Financing

Access to recreation, educational, and cultural opportunities is limited today. While the provision of improved transportation facilities to counteract isolation and to advance the mobility of the aging would address one dimension of the problem of access, action in other areas is also desirable. When opportunities are limited, access is limited. Outside of larger urban areas, access to opportunities varies, but is most often poor despite improvement over the last decade. The provision of a wider range of opportunities for participation outside the larger population centres is an area for action.

Expanding the limited range of opportunities available to the aging is perhaps ancillary to the question of what opportunities should be promoted. Promoting the well-being of the aging involves taking into account that they are not homogeneous. A meaningful opportunity for one can be meaningless to another. If supporting and encouraging the development of opportunities meaningful to the aged as individuals and in groups is an objective, then it would appear that the broadest possible perceptions of what education, culture, and recreation are must underlie the support and encouragement governments offer both today and tomorrow.

The type of financial support offered in various areas is itself an issue. Variations in commitment and funding by governments can have a deleterious effect on programs, services, and voluntary activity affecting the aging. For the voluntary sector, a more consistent approach and commitment to supporting various types of activities would assist in the planning of their undertakings.

Education

In education, a variety of current issues exist. It is noteworthy that current participation in education is minimal. The timing, location, structure of courses, and pedagogical techniques often make enrolling in what is presently available inopportune. Indeed, persons ill-at-ease in classroom settings or simply uninterested in credit-oriented course content often do not participate. Yet, if learning opportunities for the aged are developed with a presentation and content structured to what is meaningful to them, the consensus of research comment is that more would become involved and that skills learned therein would better prepare the aging for new roles and self-determined vocations.

Critical to the education process is the need to expand planning for retirement and, indeed, perhaps to orient it more to the family of the retiring person. Such pre-retirement planning should include providing the pre-retired with information about opportunities to participate in community and social activities, with encouragement to do so. It should include information on counselling services which address the problems stemming from abrupt lifestyle changes, including alcoholism. While some private sector employers offer pre-retirement educational opportunities, in general the private sector should be encouraged to develop flexible work schedules for persons close to retirement so that their introduction to leisure can be a gradual rather than abrupt process.

Culture

Older persons should be encouraged to continue to pursue cultural activities followed over a life time. Interest in drama, literature, art, and music does not cease at age 65. Those who have not developed an interest in earlier years may be challenged to become involved. The likelihood of producing great dramatists or artists is not the intent, although older Canadians have become famous in careers undreamed of in younger years. A good example is the late Chief Dan George.

Society's disregard for the talents and skills of the aged has tended to make them feel inferior. The media, educational institutions, libraries, museums, galleries, and theatres have important functions to perform in helping the aged improve their self image and the image society has of them. The goal is to stimulate every older person to a commitment to a specific interest. Whether this is history, jazz, cooking, bird watching, literature, art, or any one of literally hundreds of interests, is unimportant; the quality of the dedication is the important thing, not the nature of the study.

Departments of government at all jurisdictional levels that are concerned with developing and supporting cultural activities could aid financially as appropriate. But giving leadership in helping the aged to appreciate their potential can be equally important. A good example of this is the study of the Performing Arts and Senior Citizens in Alberta, commissioned by the Minister of Culture for that province. It documents the involvment of the aged and makes recommendations.

Identity, meaning, love and wisdom are the spiritual needs of every person, including the aged. Every person, rich or poor, advantaged or disadvantaged, has a right to achieve a sense of spiritual well-being. Cultural heritage is intimately linked with it.

All areas of human activity are embodied in the term "spiritual well-being". Included are those aspects of life related to a person's inner resources - especially the ultimate concern, the basic value which serves as the focus for all values, the central philosophy of life - which guide a person's conduct whether the individual is religious, anti-religious, or non-religious.

The art of successful living, and therefore of successful aging, links mind, body and spirit. Thus in Canada, where deeply held values are woven into the heritage and culture of the country, the need to fulfil the spiritual well-being of the aging should be as dominant a concern as the need to satisfy their physical, material, and social needs.

DEVELOPMENTAL ISSUES

Economic

Social

Political

ECONOMIC

INTRODUCTION

A major change in the demographic profile of a nation, such as the gradual aging of a population, will have implications for economic growth. As the population ages, fundamental shifts will occur in its composition that affect the various economic processes, such as changes in the patterns of consumption, savings, investment, and ultimately in the rate of economic growth. A reduction in the relative size of the working population may result in a decline in per capita output in the economy provided technological and capital changes do not offset such a decline. Possible increases in taxes and private transfers to support the aging may impose additional disincentives to production. Persistent, high rates of inflation could pose serious problems for society as a whole, and for the aging since indexing provisions are not in widespread use. On the other hand, if policies are adopted to stimulate economic growth, improve the productivity of the labour force, and encourage the adoption of technological advances and innovations, potential negative effects on economic growth may be partly or entirely offset.

Factors promoting economic growth are important in determining the ability of the country to finance continuing and possible new programs to enhance the health, income security, social services and social participation of the aging. The aging may be further affected as economic, social and political institutions adjust to changing demographic realities.

The financing of expanding programs for the aging could engender concern as the economy is faced with competing demands in many other areas. The performance of the economy can have considerable bearing on the strategies or policies that may be implemented to improve the positions of the aging in society, particularly in respect to the services to be provided to dependent aged persons, the adequacy of retirement incomes and the social participation of this group.

An area of particular concern, which has high future cost implications, is the development of an improved retirement income system for Canada. An improved system may have significant economic consequences, affecting consumption, savings, investment and economic growth. The elements of such a system now exist, though many of its components have not fully matured and its major gaps and deficiencies have not yet been corrected.

Institutional and attitudinal barriers to employment past the usual age of retirement, including mandatory retirement, have contributed to declining labour force participation for those over age 65. These barriers have imposed hardships, financial and otherwise, on the aging worker who wishes to continue working, and have resulted in a loss to the economy of the skills, training, experience and knowledge of these workers.

This section examines general economic issues relating to an aging population, income security, employment of the aging, and enhancing the efficiency of public programs for the aging.

GENERAL ECONOMIC ISSUES

Future Economic and Social Balance

(i) Balancing Economic and Social Development

As the aging population increases over time, a need for increased spending on social programs could arise. These programs in turn could affect the various processes in the economy. The obvious goal would be to achieve the best possible spending balance between social and economic development.

High levels of spending on social programs, however well justified by identified needs, could, over time, seriously erode the economy's ability to generate the income necessary to sustain and improve services. Social program development would have to be balanced against economic growth. Establishing social and economic priorities may be necessary owing to resource limitations.

(ii) Dividing Future Economic Resources Among Competing Needs

Studies of public expenditures indicate a significant difference in the cost of supporting an elderly, as opposed to a young dependent population of the same size. While insufficient evidence exists on private expenditures for both groups, a recent Treasury Board of Canada study suggests that per capita federal and provincial government expenditures may be three times as high for older persons as for younger persons.

Increases in the numbers of the aging can reasonably be expected to add to costs of at least some of the following programs: hospital and medical care, home care, institutional care, income support, pensions, housing, and social and related services. Some of these higher costs may be partially offset by declining expenditures on young persons following a reduction in their relative numbers, by financial savings from promoting more effective and efficient programs, and by eliminating waste and duplication among programs.

The rate of economic growth and the pace of technological advances are important factors in determining how well the country may be able to finance expanding and new programs to meet the future needs of an aging population. The optimal balance between the allocation of present and future economic resources will depend on a number of interrelated economic, social and political factors.

If costs rise less than revenues, financing programs for the aging should be no problem. Similarly, if costs and revenues increase at the same rate, there may be no problem - assuming that the increase in revenues is not diverted to other programs. Should costs outstrip revenues, problems could arise in financing programs if there are to be no cut-backs of programs for the aging and of other programs.

Dependency

(i) Economic Dependency Ratio

The interaction between demography and economics has traditionally been expressed by the ratio of the dependent population to the independent working population using chronological age as a proxy for economic dependency. Young and old persons are considered to be relatively less productive; their consumption needs being provided in part by the working population. Use of the traditional labour force or "working age" to "non-working age" dependency ratios has, however, ignored the major underlying issue of adequately defining economic dependency and of assigning costs. It is not possible to establish meaningful ratios of economic dependency until the total costs of raising, educating, caring for, and supporting youth to maturity and of maintaining, caring for, and supporting aged persons can be determined. Further, dependency ratios should include appropriate adjustments for unemployed persons at any given time. In this regard, if higher levels of unemployment become persistent in the future for all industrial economies, including Canada, the sustained level of unemployment must be part of a calculation of dependency even though movements in and out of unemployment are not confined to a particular set of individuals. The economic balance between the working and non-working populations should be based on more accurate and more pertinent factors.*

(ii) Demographic Effects on Aggregate Consumption and Savings Resulting from Changing Dependency Relationships

As the elderly population in Canada increases and the degree of economic dependency of the non-working population changes, effects on aggregate consumption, savings and economic growth can be expected. A study by the Government of Ontario in 1979, Issues in Pension Policy, examines this issue. The study looked at the concept of "committed" consumption - i.e., the income transferred from the working population to pay for the consumption needs of non-workers. With shifts in population, both the economic dependency ratio and the amount that workers commit to the consumption of dependent persons will change. A change in the economic dependency ratio may also affect aggregate consumption, i.e., the consumption of workers and non-workers, and the amount that workers save.

The patterns of savings and consumption change over the life cycle. The age distribution in the population at any given time affects the aggregate personal savings rate. If the middle-aged group predominates, the aggregate personal savings rate will be high. If the age distribution is skewed to one end or the other of the age range, or to both ends, the savings rate will be relatively low. It has to be borne in mind that the effect of demographic shifts on the rate of personal savings is not the only factor affecting aggregate savings. For example, a deficiency in aggregate personal savings may be made up by increased savings in other sectors of the economy.

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* Different measures of dependency are discussed in:
Stone, Leroy O., Background Paper on the Demographic Aspects of Population Aging in Canada, Revised January 21, 1982, Statistics Canada, Ottawa, Ontario (Unpublished).

INCOME SECURITY

Providing an Adequate Retirement Income for Aged Canadians

One of the prime developmental issues is the provision of an adequate retirement income for aged persons in Canada. Consideration of this issue can be expected to involve study of the various programs making up the current retirement income system in Canada; identifying problems to be resolved; searching out ways to improve programs; examining how programs may be effectively co-ordinated and integrated; determining equitable and effective relationships among public sector, private sector, and individual efforts in providing retirement income for the aging; and ensuring that aging persons of both sexes are equitably treated by the retirement income system.

Although the stream of earned income is interrupted by retirement, it is a generally accepted principle that those in retirement should be able to maintain the standard of living to which they have become accustomed during their working lives. Too often, however, the replacement rate of income in retirement is insufficient to allow for this, particularly if unforeseen and on-going large expenditures arise. For such cases, financial help may be required. For some, income may be insufficient to meet basic needs from the outset of retirement. Protection against the risk that basic incomes will not fall below a specified level of income has long been a generally accepted principle; a goal yet to be realized for some.

The following issues are matters of concern in providing an adequate future retirement income for aging Canadians: the need for a basic income guarantee; the roles to be played by the public pension system [Old Age Security (OAS), Canada Pension Plan (CPP) and Régime de Rentes du Québec (RRQ)] by employer-sponsored pension plans and by savings; and, the treatment of women within the pension system.

(i) The Need for a Basic Income Guarantee for the Aging

Until the pension system in Canada is reformed and until retirement incomes delivered thereunder are adequate, large numbers of older persons will reach retirement age being largely dependent on income support available under Old Age Security, Guaranteed Income Supplement, and Spouse's Allowance (OAS/GIS/SPA). Policy makers will need to decide how best to deliver a basic income guarantee, and the levels of income to be guaranteed. A number of options are possible for delivering payments: improving OAS/GIS/SPA, integrating a basic income guarantee into the CPP/RRQ, or setting up an entirely new arrangement. Deciding upon the basic minimum levels of income to be guaranteed will not be an easy matter because of economic, social and political considerations.

(ii) The Role of the Public Pension System (OAS, CPP, RRQ)

In the long run, a more direct link between pre- and post-retirement incomes and higher replacement rates may be possible through strengthened contributory pension plans. Through these, the levels of benefits and of costs are more closely related.

Expansion of the CPP/RRQ has been advocated as an efficient and effective means of improving pension coverage and providing adequate pension income. Problems inherent in employer-sponsored plans such as portability, vesting, and protection against inflation do not exist under the CPP/RRQ. Current benefits provided by the CPP/RRQ are, however, low, being 25 per cent of average adjusted contributory career earnings. In order to raise benefits, significant increases in CPP/RRQ contribution rates would be required. The bulk of money generated from these additional contributions would be funds transferred from the private to the public sector. The impact of the change in the flow of these funds on the economy has been a topic of debate. There is no evidence that the present CPP/RRQ has had any adverse impact on economic activity. Given the possibility of increased contributions and benefits, their impact on the economy would, however, have to be examined.

Currently, CPP legislation provides for the investment of contributions collected annually, less the amounts needed to pay benefits and administrative costs. These excess funds are made available to provinces (other than Quebec which has a comparable pension plan) for investment using a formula set out in the Act. With fundamental changes to the CPP, the control of these funds and how they are invested may have to reconsidered by governments.

Even without any changes in current benefit levels, contributions under the CPP/RRQ will have to be increased to meet future obligations. Funding implications of increased contributions will require careful review, as will the regressive impact of increased contributions on contributors.

Governments, employers and unions could do more to assist financial planning for retirement. For example, the CPP/RRQ might be amended to provide estimates of retirement benefits several years prior to retirement. Private pension plans might be encouraged to do the same. If this were done in conjunction with other measures of assistance by employers and unions, financial planning for retirement would be greatly facilitated.

(iii) The Role of Employer-Sponsored Pensions

There has been growing awareness in Canada that the system of employer-sponsored pension plans is in need of improvement. The high inflation of the 1970s produced a rapid erosion of private pension benefits, and a growing dependency on government-sponsored income support programs. Increasing labour mobility has resulted in many workers accumulating small pensions because they lose credits when they change employers. Women do not receive adequate treatment as plan members or as spouses of plan members. Matters such as vesting, locking-in, and portability are urgently in need of reform. Protecting benefits against price inflation, and determining how to improve the disclosure of information on the nature of pension plans and benefit entitlement are other issues to be addressed. Reform of pensions involves determining the appropriate vehicle for bringing changes about. One suggestion has been to set up mandatory private pension plans. Since almost all employer-sponsored plans are under provincial jurisdiction, a co-ordinated effort between the federal and provincial governments would be needed.

(iv) The Role of Individual Savings for Retirement

Currently many persons in Canada save for their retirement using instruments developed to encourage savings. A system of Registered Retirement Savings Plans (RRSP) has emerged in Canada. Under an RRSP, contributions up to certain annual limits are tax deductible; the accumulated interest on these contributions is also non-taxable. The proceeds of an RRSP are only taxable when a withdrawal is made. Many persons make use of these plans to save. Included are: self-employed persons, workers not covered by pension plans, workers covered by pension plans but wishing to supplement their pensions, and workers making contributions to spousal RRSPs. At issue for the future is the determination of the precise role that RRSPs and other retirement savings instruments are to play in the future retirement income system for Canada.

(v) The Treatment of Women Under Pensions

Over time, more women will be entitled to pensions as increasing numbers participate in the labour force. The smaller benefits paid to women as compared to those for men reflect the lower earnings they have generally received as a result of being concentrated in lower-paying occupations, and the longer periods they spend outside the labour force raising their families. Women are also penalized by their predominance in part-time employment.

There are a number of issues to be considered if the equality of treatment of women with men under public and private pension plans is to be improved. One issue is whether or not pensions should be provided for homemakers*, and, if so, whether under a separate public program or through existing public schemes. Another is to consider the making of changes under employer-sponsored plans to minimize loss of pension credits to women who leave the labour force while they are raising children at home; and, to seek to have this feature, in effect under the RRQ, ratified for the CPP. Yet another issue is to try to have private pension plans set up provisions to share pension credits between spouses on marriage break-up, as is done under the CPP/RRQ. Other issues to be addressed include pension provisions which discriminate against women, and the provision of inflation protection of benefits payable by employer-sponsored pension plans.

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* Homemaker used in connection with pensions means the spouse, not attached to the labour force, but whose work is caring for home and children. It does not apply to a "homemaker" who provides a social service through a program, e.g., a home care program.

Means to improve the earnings of women could involve: equal pay for work of equal value; providing more opportunities for women to get job advancement including higher-paid jobs; offering more guidance in career development; providing more opportunities for their continuing education, training and retraining throughout their working lives; and improving child care arrangements.

Determining the Impact of Pensions on the Economy

It is not possible to say precisely what the nature and structure of the public and private pension systems in Canada will be by the end of this century. Significant changes in the current pension system would likely have significant effects on the economy; certain studies have already been done to develop partial models of different system options. The assessment of such models is quite complex. Optional ways of financing the public pension - partial or full funding, pay-as-you-go, or government revenue financing - each have a different chain of effects on the economy. Definitive assessment awaits definitive specification of the future system.

Determining an Equitable Relationship Between Public and Private Sector Support for the Aging

The state, the individual and the employer should each contribute in an equitable manner towards the provision of income support for retirement. At issue for the future is the determination of that portion of the responsibility to be borne by each of the parties which would be equitable and acceptable to all parties involved.

EMPLOYMENT OF OLDER WORKERS

The extent and the methods by which Canadian society will use aging persons as an economic resource are critical issues for Canadians in the future. Much will depend on the future demand for labour and how this can best be supplied. Given a labour shortage, encouragement of the aging worker to remain in the labour force could become a policy imperative. Even without a labour shortage, there may be quite valid reasons why the employment of older workers should be encouraged, namely: lessening income support costs, making more productive use of skilled and experienced resources, and improving the health and emotional well-being of the aging. Critical to the discussion are three specific time periods: pre-retirement, retirement and post-retirement.

Pre-Retirement

Older workers who are unemployed due to lay-offs and plant closings tend to be unemployed for longer periods than younger workers. They tend to stay in areas where they have lived over time, and generally do not seek employment in locations further afield, having little economic or social incentives to do so. With reduced mobility and higher unemployment, not only do older workers lose wage and salary income, but they are not able to continue their contributions to public (CPP/RRQ) and employer-sponsored pension plans.

With the application of new technology to production, older workers tend to become redundant. Many employers are reluctant to train older workers to use new technology, because the return on these investments will be less the closer the older worker approaches the age of retirement. Subsidies based on a sliding scale might offset this situation to some extent. International evidence shows that, generally speaking, the older worker takes longer to learn than his/her younger counterpart. Other evidence has shown, however, that the older worker tends to be a more stable employee, less inclined to be absent, more productive and more loyal to the job and the employer.

Aging workers who immigrate to Canada in their later years will only become eligible for partial pensions benefits under Canadian social security programs. Some immigrants may receive social security pension benefits from their home countries without an international agreement between Canada and their country. Other immigrants, even though they may have social security credits in their own countries, may not benefit from these without an agreement. Agreements may be necessary to allow for the payment of another country's benefits to entitled beneficiaries in Canada, or to permit, when required, the use of another country's social security rights to become entitled to Canadian pension benefits. Agreements help to improve the income position of certain immigrants to Canada. Ancillary to this, workers in other countries having social security rights under Canada's system may be able to use these rights to establish eligibility for benefits in their home country when an agreement exists between their country and Canada. While Canada has agreements with several countries, most countries have not yet entered into such agreements.

Retirement

Flexible retirement allows employees to choose when they retire, just as self-employed persons do. Mandatory retirement requires employees to retire at a specified age, whether they want to or not. In 1982, Quebec enacted the first legislation in Canada that prohibits mandatory retirement. The Charter of Rights in the Canadian Constitution and existing human rights legislation across Canada provide varying degrees of protection against discrimination on the basis of age.

Rationally, an individual, unless compelled to retire because of ill health, who is given the flexibility to determine the time of retirement, would view income adequacy in retirement as a major factor in considering when to retire. To permit early retirement, pension entitlement requires adjustments consistent with years of service and/or contributions.

Given flexible retirement a person could work to any age, regardless of how old this may be. If flexible retirement were adopted as a government policy, mandatory retirement provisions would have to be removed in the jurisdictions affected. It could be expected that assessment procedures to determine capability and suitability of workers to continue in employment would undoubtedly be required. In establishing any system of flexible retirement, care would likely be needed regarding incentives respecting early retirement, as well as care in avoiding the imposition of heavy financial penalties on persons wishing to continue working.

Flexibility would also be needed by policy makers in government, business and industry in determining retirement age, levels of benefits, and changing labour force needs. Complicating factors inherent in the development of policies will be recognition of both employment needs and opportunities that vary by region, occupation, business, industry, as well as individual differences in health status and work preferences. Since all signs point to the elimination of any fixed age for retirement, one part of the developmental issue is how to set the conditions in order that individuals will be allowed the greatest measure of choice while being ensured of adequate income security during retirement. The other part of the issue entails the need to ensure high productivity for the employer and consider the manpower needs and economic resources of Canada. Since attitudes and expectations regarding retirement, manpower needs, as well as the demands upon the economy, will not remain static, neither will the policy decisions of the 1980s endure for the next 50 years.

Broadly speaking, the economic developmental issues regarding flexible retirement are: the option of the individual to choose continued work or leisure; and the need for better methods to evaluate the job performance of older workers who wish to continue in employment as an alternative to mandatory retirement. In financial terms, the issues are: the increasing burden placed on social security and pension plans by demographic changes and the increased longevity of persons who retire; and the high cost of early retirement and of provisions based on service regardless of age.

Post-Retirement

A 1980 study by the Conference Board in Canada on the effects of removing the mandatory retirement age showed only a negligible effect on employment past the age of 65. Further, there is no evidence that great numbers of persons wish to continue in employment after age 65. The Department of National Health and Welfare; Retirement in Canada Survey of 1975 showed that 31 per cent of retired males - had their pensions been sufficiently large - would have retired earlier, although 13 per cent would have taken part-time work if it had been available. As attitudes towards working to later ages change, and if labour shortages should occur in the future, this situation could change, possibly quite significantly.

There may be many older persons who wish to continue working if they have the option to do so. There are a number of reasons for this. They may need additional income; work may have a positive influence on their physical and mental well-being; or their occupation may be a vocation and not just a job.

If mandatory retirement is abandoned, it may become necessary to promote new types of employment arrangements, including part-time employment, and to encourage employers to provide work opportunities for older workers. There are a number of options available: shared work arrangements, reduced hours of work, flexible work schedules, job modifications, and graduated retirement schemes.

TOWARDS A MORE EFFICIENT SYSTEM OF PUBLIC PROGRAMS FOR THE AGING

Confident that Canadian society will want to provide the range of programs necessary to foster the well-being of aging persons within the limits of available financial resources, there is an underlying assumption that these programs should be provided at the least possible cost. An important factor is the need to develop co-ordinating and planning strategies and structures. This could reduce overlap, duplication and waste in programs and delivery systems. Finally, for all programs within the system, efficiency and effectiveness could be enhanced through regular, independent evaluations.

SOCIAL

INTRODUCTION

Changes in society occur as a result of the aging of the population. In turn, these changes affect the aging themselves. The family, employment, health and social services, income support, and the like will all be influenced. Economic and social issues that reflect these changes are emerging; they can be expected to become more critical over the next few decades. The degree to which the rapidity of economic and social changes is recognized by society and governments, and their success in taking them into account in their planning and adjustment, will determine whether or not dynamic growth continues to be a mark of the country. Developing effective strategies that respect regional differences and desires, but do not lose sight of the need to co-ordinate efforts in order in effect the goals of the country as a whole, will represent an on-going challenge.

Efforts to enhance the quality of life of individuals and ensure the well-being of both individuals and society require a broad range of economic and social policies, commonly referred to as social security. Economic constraints may, however, inhibit the attainment of this broad objective. Continued social progress depends upon the identification of priorities and the development of the most appropriate policy responses, taking into account the best available forecasts of the levels of economic growth. Further, the extent to which social measures interact with economic growth arises as another factor for consideration.

Social progress has been viewed as a result of economic progress, although admittedly not automatically generated by it. A matter currently being debated is whether or not future social progress might not provide the stimulus, or at least _a_ stimulus, for economic recovery now that economic progress is slowing down.* Like many such concepts, it has its advocates and opponents.

As will be evident from the foregoing, difficulties occur in trying to separate the economic and social issues. The economic issues have, however, been set forth in an earlier section. The purpose of this section is to delineate the social issues that may be dominant over the next 20 years.

The order in which the social issues are presented intends no priority. From the present perspective it is predicted that all will be subjects of debate; all will generate options for consideration in arriving at solutions, the choice of which will not necessarily be the same in all regions of Canada. Further, solutions deemed appropriate for the 1980's may be modified, even changed completely, with the passage of time.

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* Organization for Economic Co-operation and Development, _La Politique sociale dans les années 80_, Paris, 1980.

The impact of the aging population will not be fully felt until the first of the post-World War II baby boom reaches age 65 in 2011. There is, therefore, lead time to explore the issues and seek the most appropriate solutions. But since gathering data, developing programs, and testing results cannot be hurried, the time may prove to be barely sufficient.

WOMEN

Women today marry later, have fewer children, and have more sexual and social equality than in the past. Whether or not their labour force participation rate will continue to rise is unknown. It is, however, clear, that building flexibility into women's life cycle patterns should continue throughout life, as it should for men as well.

Since there are more women than men in the population aged 65 and over, and the majority of them are single (widowed, never-married, or divorced), they can be expected to have special relevance for future policy makers and planners concerned with social issues. This reference to women has been introduced here to serve as a reminder that in considering developmental issues in the social arena, women will make up the majority of the aged population affected by them.

HEALTH AND SOCIAL SERVICES

Overcoming the dichotomy that still exists between health and social services is critical in so far as aged persons are concerned. When a service is needed at a particular place and time, it is not its arbitrary classification that is relevant but rather its availability. The objective is to have as wide a range of services as possible to meet the health and social needs of the aged, and by implication the resources to deliver them.

The social issues that could accompany the development of these services may include:

(a) making the best choice(s) in the development of the most efficient, accessible, and economical care arrangements to serve the needs of the greatest number of aged persons;

(b) establishing training programs for health and social services' personnel in the care of older persons;

(c) developing methods to provide training for families in the care of their aged members;

(d) establishing ways to ensure an equitable distribution of service personnel throughout the country, including the metropolitan inner cities as well as the rural areas;

(e) establishing and/or extending programs aimed at reducing the reliance on institutional care, e.g., home care, health maintenance, and social service support programs;

(f) developing cost control procedures that encourage the fair allocation of health and social resources to all geographical areas, as well as appropriate incentives to providers and consumers to be cost conscious; and

(g) establishing quality assurance mechanisms such as minimum standards for licensing, and desirable standards to be achieved; continuing education requirements; and comprehensive health and social planning arrangements.

If the improvement of the health status of Canadians is to be taken seriously as a goal, both the methods to achieve it and the resources to effect it constitute social issues to be resolved. Greater stress upon personal responsibility for one's self care, health, and well-being may be reflected in actions taken by governments and non-governmental agencies. For example, some insurance companies offer non-smokers lower rates for home and automobile insurance - a reward for a reduction in hazards; governments, on the other hand, have introduced seat belt legislation - a measure designed to protect life and reduce injury in the event of accident. Other means to encourage individual efforts in health promotion and protection might in future be added to those currently in effect.

A safe environment is critical if health promotion and disease prevention programs are expected to have desirable outcomes. Pollution, including air, water, soil, and noise, can have implications over a life time.

Measures to prevent disease and protect and promote health should begin in infancy and be reflected in life-long practices. During the middle years, however, there may be considerable back sliding brought about because of family and job pressures that reduce both time and incentives to engage in personal health goals. With advancing age, the poor habits acquired may lead to disease and incapacity. Modification of these human behaviours may substantially improve present and future health prospects.

Getting people to participate in health protection and promotion programs, not to mention immunization programs designed to prevent disease, represents a major problem. Further, occupational health and safety programs that offer protection in the workplace may be non-existent, limited, or followed with little enthusiasm on the part of either employers or employees.

The commitment of human and economic resources has, to date, focused attention on the curative, as opposed to the preventive, aspects of health. With an increasing aging population, reductions in the costs of health care are not likely, but the possibility of their containment might be be worth exploring. Success could depend upon the degree to which society is committed to improving the health of Canadians, and willing to allocate the necessary resources to accomplish the task.

Developing a comprehensive policy and the strategies to carry it out are inherent in such an undertaking. Some of its objectives might be to: enhance the quality of life; postpone disease; develop protective measures against health hazards; classify the competing causal factors of morbidity, disability, and mortality; and make judicious choices in order to develop the best cost-effective mix of preventive/control/service/treatment strategies in accord with the stated social policy.

THE AGED AS A SOCIAL RESOURCE

The sections dealing with employment and economic issues refer to some ways that the aged who remain in the regular labour force could continue to contribute to the productivity of the country. The knowledge and skills acquired over a life time can also continue to benefit the community and its organizations. Therefore the potential of the aged as a social resource should not be overlooked.

Older people will never cease to be the important link in passing on the family history as well as the local history and cultural values to society's younger members, even though their role in preserving the country's history has been diminished by technology. Corporations have long recognized the importance of appointing older community and business leaders to their boards of directors. Community programs and organizations, hospitals, institutions for the care of the aged, and the like could capitalize upon this idea. Further, older persons can participate in services as wide ranging as day care for children and foster grandparents to senior companions and organized home care; and from hospital and library programs to those offering senior and one-parent family counsellor services. They can be active participants in theatre, arts, music, and sports endeavours.

Two essentials are necessary to bring about the effective utilization of the aged as a social resource. First is a change in attitudes on the part of society that reflects both a recognition of the abilities of the aged and a willingness to use their talents. The other aspect is a change in attitudes of the aged themselves. Confidence in their own abilities and those of their peers is needed, of course, but unless this is matched with a determination to prove their worth and a willingness to undertake commitments that may be demanding, important opportunities may be lost.

UNIVERSAL VERSUS SELECTIVE PROGRAMS

Whether to program around a constituency group or around a specific problem area can be expected to continue as a dilemma for policy makers. While a problem may reside within a constituency, the efficiency of constituency programming may be questionable since benefits are diluted by being spread across a whole class of people, some of whom need the benefits while others do not. Some examples serve to illustrate.

Because the majority of the population may be expected to require medical and/or hospital care at some point in time, the need for universal medical and hospital care plans is no longer a subject of debate. On the other hand, some argue that geriatric assessment units in general hospitals are not needed by all aged people and their scope, therefore, should not be extended. They have staff qualified to undertake an intensive appraisal of the health and social needs of aged patients who require specialized help. Such units serve as an example of a development geared to a sub-group of a population. There are, however, those who argue that all older patients could benefit from the thorough assessment they provide.

Selective programs may tend to segregate, even isolate, those they serve. This is in direct opposition to those programs and services that seek to maintain the aging as a part of the total society, and re-integrate those who have been shunted outside the mainstream. Social integration is cited as a major pillar of societal strength. Thus those contemplating selective programming may wish to explore thoroughly those factors that could contribute to the segregation of the users in order to minimize their effects to the greatest possible extent. In focusing upon the perceived negative aspects of selective programming, there is a possibility that programs that represent "positive discrimination" could be overlooked. Good examples include Old Age Security and the Guaranteed Income Supplement.

AGE INTEGRATION VERSUS AGE SEGREGATION

Age segregation of children in schools, organizations and programs appears essential and appropriate in teaching them to become adults; the idea being that increasing responsibilities go hand-in-hand with increasing maturity. Thus age segregation serves as an instrument of social integration. In the senior years, at the apex of maturity, age segregation is invoked for reasons unrelated to human development. There are, however, instances when segregation can be demonstrated to be essential and beneficial for the well-being of the aging. For example, older persons who no longer require the active treatment provided in acute care hospitals are not well served in that environment.

Generally speaking older people express the desire to remain part of the total society. Many continue to engage in a life style that is conducive to active association with those in younger age groups. Some create a good balance between participation with their peer group and with other age groups. Finally, there are those who deliberately seek a segregated society; such selective segregation is found in retirement communities. Segregation for others is not by choice; it may, for example, be the result of economic necessity that no longer allows them a free choice of accommodation but forces them to live in subsidized housing for senior citizens.

Developing the most appropriate mix of options that permit the aging to make choices to meet their needs and wishes is the desirable goal. In so far as possible, allowing individuals to select the degree to which they practise integration or segregation, without a value judgement regarding whether it is "bad" or "good", could resolve an issue that may be more a reflection of the view of care givers than of the aged themselves.

CO-ORDINATION AND INTEGRATION

Co-ordination is identified in the social, economic, and political developmental issues as a major goal to be accomplished in the field of aging. The need for it in respect to the health and social services exists at the policy development, planning, organization, implementation, and delivery stages. All levels of government are involved in these processes, as are a multiple number of agencies in the non-governmental sector. This has resulted in confusion on the part of the general public and has led to a widespread belief that there is no rhyme nor reason to the health and social service systems. This perception may be partly due to the lack of co-ordination resulting from competition, duplication and overlapping of programs and services between governments; within, and between, departments of government; and between non-governmental agencies and government.

Consultation is important in effective co-ordination. There are, however, insufficient networks to encourage and allow for on-going consultation between all governments and their agencies concerned with policies and programs for the aging, and between the governmental and non-governmental sectors. This is not to say that there are no consultations; but rather to say that in the interests of promoting co-ordination, the development of a strong and efficient consultation process might be worth considering. It could be important in making the optimum use of scarce resources, in determining how best to meet the needs of the aged through the multiple range of programs available to them in the different areas of Canada, and in evaluating progress.

Consideration in the evaluation process could include an analysis of the extent to which different services are responsive to the needs in the population; an exploration of how services might better reach individuals in need could result from this. How the organization of services shapes utilization patterns, and the most appropriate organization for improving the integration of services, are other possible avenues for attention.

Integration is associated with co-ordination. Several provinces have already achieved some success in integrating the delivery of health and social services, particularly those in community care. Integrating other services where such action is judged desirable and feasible, in order to meet the needs of the aged, offers a possibility for future consideration. Extending the integration of services more widely might effect economies in the use of resources.

THE RURAL AND URBAN AGED

Rural communities need the aging as much as the aging need the rural communities. A declining farm population, coupled with the exodus of young people, makes the buoyancy of towns and villages dependent upon the economic contributions of their older citizens. The numerical support they give to a variety of community activities and organizations is also vital to these small centres. Many of the aging have been self-employed and have valuable experience in running their own business. The resulting financial and administrative expertise, combined with a public-spirited outlook, are invaluable assets in a town or village where self-help is the only way of ensuring that the community keeps going. In short, it is in the best interests of the community to make it an attractive place for the aged to live.

Most of the health, social, and recreation services in the rural communities were developed by governments; first in response to the needs of the young population, and more recently to provide care for older people unable to care for themselves. But the infrastructures, planned and built during the baby boom with particular emphasis on younger citizens, do not necessarily fit the needs nor aspirations of those in the later years.

Examining, evaluating, and where necessary altering the existing social, physical, and economic structures to accommodate the needs of the aging population in rural communities, appear to be the first steps to be taken in the development of appropriate social policies to serve both the aged themselves, and the communities in which they live. Strengthened communication links between older citizens, local and provincial governments, and volunteer groups and agencies could be a means of focusing attention upon the issues of concern to the older members in the rural society.

The influence that the older citizens exercise upon the towns and villages is not matched by their counterparts in cities and metropolitan centres, where about two-thirds of Canada's older population lives. Those in these urban centres, especially the ones who are economically and socially disadvantaged, tend to congregate in sub-areas of the urban conglomeration, either in the inner core, as in Winnipeg, or in the suburbs, as in Toronto.

Those engaged in planning initiatives for redeveloping or revitalizing urban cores, or well established suburban areas, have a responsibility to be conscious of, and take into account, the special needs and concerns of a segment of the population which has generally been politically "invisible". Where multifaceted strategies of redevelopment are attempting to affect all aspects of the urban complex (housing, employment, health and welfare), a sensitivity to the existence of the aging residents in terms of ensuring a participatory role in identifying priorities and mechanisms for redevelopment thrusts can be most important.

BALANCING PERSONAL INDEPENDENCE, INTERDEPENDENCE, AND PUBLIC RESPONSIBILITY

The general expectation on the part of society is that individuals should function as independently as possible and assume overall responsibility for their own well-being, and that of their families. This concept of individual responsibility implies that planning to meet present and future needs will be undertaken. In Canada, however, either governments, the church, or voluntary organizations, depending upon the region of the country, historically predominated as the agent which provided for those unable to support themselves.

Over time the idea that governments, on behalf of the people, should assume responsibilities which previously were considered to belong to individuals and families, has taken root; the hospital and medical care plans, Unemployment Insurance, and the Canada and Quebec Pension Plans serve as examples. Thus a sharing between the individual and the state has become accepted. The line of demarcation is, however, not sharply defined; it could shift with changing economic and social conditions.

An interdependence aspect is reflected when the family serves as the broker for its older members in obtaining required services. Meeting this responsibility may be difficult. Family members may not be readily available or may have legitimate reasons that keep them from assuming the role of broker. Further, there are aged persons who have no family. Undertaking a broker's role is time consuming; finding appropriate solutions may present complex problems; and serving as the mediator between the individual and the service may be stressful. Families need help and encouragement. This societal issue may be one where governments could play a part in the development of a mediating structure. Included might be advisory and counselling help to assist families in carrying out their responsibilities; and the provision of an ombudsman service to act on behalf of families unable to assume the brokerage role and for those without families.

Wide variations in the behaviour and ability of individuals are reflected in the degree of success achieved in their preparation for the later years of life. The extent to which an equitable balance is attained between state and individual responsibilities, so that the individual retains the greatest degree of independence, and the state avoids both under- and over-provision while maintaining credibility in the eyes of those who have managed through their own efforts to look after their needs, represents a social issue of some magnitude.

TECHNOLOGY

Flexibility and access are the themes reflected as major issues for technological policy development. Both are highly sensitive to changes in the per capita consumption of energy and material resources. Technological policy for an aging and economically growing consumer society differs from that for an aging conserver society. The former represents an unconstrained future; the latter a future constrained by scarce resources. Current trends appear to predict the latter.

As the population ages and resource consumption levels off, the question of flexibility in technology becomes critical; finding ways to design technologies and facilities adaptable to societies and individuals of different ages becomes a major challenge. For example, if housing environments relevant for all of people's lives can be designed, the chances for personal and social stability and an enhanced quality of life are increased. Technologies in the transportation and communications' systems that can be adapted to the needs and abilities of different groups are more desirable in terms of coping with changing age structures. The telephone is a good example of a technology which has been adapted for use by people with various physical disabilities. The continued expansion of cable and satellite television and interactive videotex (called Telidon in Canada) will allow for further achievements.

Flexibility is intimately related to access. As society evolves to an older age structure, the question of access will assume increasing importance. Sometimes it can only be achieved with relatively high marginal costs which means that very difficult, and very political trade-offs may have to be made; the end result may discriminate against economically disadvantaged groups such as the aged. The decision of the Toronto Transit Commission not to build elevators as well as escalators in the subway system is a case in point. The cost of the elevators themselves was considered in arriving at the decision; not considered were the social costs of limiting the mobility, and often the productivity, of members of society. The Toronto situation is little different from the rest of the country. The important factor is to recognize that what constitutes an economic or political impediment at one point may not always do so. New methods of accounting and financing can reflect new future-oriented political priorities, and can transform proposed expenditures, which once seemed uneconomical, into very good investment. One possible goal for the future might be the development of transportation systems which do not present age-specific or income-specific travel barriers.

Economic and other barriers, inhibiting access to relevant service technologies, present opportunities to consider possibilities offered by relatively inexpensive and labour-intensive technology. It may be that expensive, resource-consuming technology "solutions" to societal problems are a thing of the past.

Consideration respecting technology should not, however, be limited to the "hardware aspects". "Social inventions", such as New Horizons, may be the most important innovations in the future; in turn, they could have an impact on technology. Attention to the changes in work and life cycle patterns may result in the kinds of social inventions that will be fully reinforced by the age structure changes that are coming about.

ETHNIC DIVERSITY

Canada has long maintained pride in the diversity of the cultures represented in her population expressed in the term the "cultural mosaic". Increasingly more races and cultures have been added by immigrants and refugees. The resulting changes in society may in time prove to be greater than those brought about by the waves of immigrants from Europe that characterized earlier developments. This ethnic diversity can contribute to Canada's growth and add to the richness of her culture.

Much can be learned about the values, networks, and social interaction of the aged in ethnic communities as a whole, as well as within the various socio-economic status groups that comprise each such community. It could be instructive to examine some of the innovative approaches taken in utilizing the skills of older members of ethnic groups in the provision of services; they continue to serve as an important community resource. A study of the relationship between good physical, mental, and spiritual health and morale, life satisfaction, cultural systems, and morbidity patterns in ethnic groups could be useful.

The aged from other lands are the repositories of the history and culture of their forbears. Imparting this knowledge to the young keeps alive their traditions thereby enriching the multi-cultural life of Canadian society.

Canada's official policy of cultural pluralism cannot claim to have built a country free from racial and ethnic tensions. Growth and maturity are, however, reflected in changes that have been realized so that older persons from minority ethnic groups can, and do, enjoy a more positive self-image.

VALUES, IDEOLOGIES, AND ETHICS

Values, ideologies, and ethics could become critical, and add emotional and moral components to the debate on some social issues. They could play an important part in the solutions reached concerning them.

So far, there is insufficient information upon which to make informed decisions about many issues. In the health care system the transfer in emphasis from acute intervention to management of the complex socio-medical problems of the aged is only beginning to take place, as is the shift from early placement in institutional care to imaginative home care. A more realistic and reasonable ethos about death, dying and prolongation of life, which the shift to long-term care may foster, has yet to emerge. An effective co-ordination of skills, facilities, and programs has hardly been attempted. Until these changes have been effected and there is time to assess the results, the costs in energy and money of providing adequate health and social care to the aged are unknown. The ethical demand on social policy is the imperative to modify institutions to serve the human good; then to measure the costs and benefits in human terms.

To define a social problem as a problem of justice does nothing to solve it, and little to modify the attitudes which support or tolerate it. It only serves to point to a discrepancy; the existence of an injustice in an avowedly just society.

An attempt has been made to take a cursory look at values, ideologies and ethics as they might become part of discussions on social issues. Ethical concepts such as morality, equity, and integrity have a history of slowly infiltrating the human consciousness, inspiring civic responsibility. Other ethical terms such as injustice, disrespect, dishonesty, and infidelity have aroused indignation and the desire to reform, and finally brought about remedies to social ills.

POLITICAL

INTRODUCTION

As the aging of the population in Canada accelerates, the perceived political power of older persons will correspondingly increase. This power might be manifested in a number of ways: their ability to organize in effective lobbying groups, their ability to create effective alliances with non-age-based groups, and their ability to make problems and issues related to the aging more politically visible through lobby groups of older persons and alliances with non-age-based groups. Older persons are traditionally more prone to exercise their franchise than those in younger age groups.

During the 1930's the first senior citizens' organizations at the local and provincial levels were established; the first national body was chartered in 1954. Today all provinces and one territory have provincial/territorial organizations; there are also several on a country-wide basis, some of which are restricted to retired employees of such industries as telephone and transportation. Further, some provincial governments have appointed advisory bodies to provide them with advice on matters pertaining to aging and the aged. At the federal level, a National Advisory Council on Aging has been appointed to advise the Minister of National Health and Welfare. All include senior citizens, all are financed by their respective governments, and all operate at arms length from government, that is, they are not part of government.

Over the years, senior citizens' organizations have endeavoured to exert pressure on governments and influential non-governmental bodies to accomplish their desired goals. Their membership has not, however, constituted a majority of older citizens. But as those now entering the ranks of the aged are better educated, more accustomed to representing the interests of their peers, and are more vigorous and healthy than their predecessors, they could be much more inclined to organize when necessary if they envisage that their life style or interests are threatened. To some degree older persons have offered themselves for public office and have become involved in community service and in working co-operatively with governmental and non-governmental bodies; this can be expected to increase. It is, however, interesting to note that the emphasis is not upon advocacy for senior citizens but for society as a whole. Given this anticipated growing ability among the aged, governments will have further reason to take their views into account in establishing policies and in the planning and operation of programs.

The remainder of this section considers other issues that have political implications.

UNIVERSALITY VERSUS SELECTIVITY

Whether a program will cover all persons in the population or in a population sub-group, or whether a program will cover a selected group of persons, raises a number of factors to be considered in respect to the issue of universality versus selectivity. Universality implies that a program or a policy is directed towards a total or particular population. For example, hospital and medical care insurance programs are total population oriented, whereas Old Age Security (OAS) is directed towards the population aged 65 and over. Selectivity, on the other hand, establishes boundaries of eligibility within a population, for example, the Guaranteed Income Supplement covers those receiving OAS whose income is sufficiently low to make them eligible.

Universal programs may be costly. They are seen to be non-stigmatizing because of their impersonality and elimination of such tests of eligibility as age, income, means or needs. Large-scale universal programs can be delivered efficiently because of advanced technology. They serve major objectives such as providing basic income support, redistributing income, or providing a basic level of services as in the case of medical and hospital care.

Selective programs are generally less costly than universal programs because fewer numbers are involved, eligibility is frequently related to income, and the population is readily defined. Selective programs highlight the needs of special groups which are often not dealt with adequately under universal programs.

It is obvious that there are advantages and disadvantages to both the universal and selective approaches. Thus in the decision making process, factors to be taken into account include: the relative cost efficiencies of the two approaches, the best mechanisms to be employed in the redistribution of income, and determining when universality or selectivity should be used so that the growing numbers of the aging can best be served by the program. Changing the criteria of established programs may have political consequences.

ALLOCATION OF RESOURCES

Demographic trends show that costs of existing programs for aging persons will escalate. Alternatively, since approaches change as new developments occur, attitudes change, and new generations of older persons with different wants, demands, and changing needs emerge, these trends may be modified. In the first instance, it could be more difficult to find funds for new policy initiatives for groups among the aging population who are not adequately served by existing policies, such as the very old, frail and dependent men and women. Public perceptions of the aging, particularly those who are dependent and in need of care, could change as costs of programs increase; if they come to be regarded more as a burden and problem, programs could come under more critical scrutiny.

The second eventuality that could occur, because of new generations of older persons and the possiblity that present trends might be modified, would not necessarily be free from funding problems. Savings from programs no longer needed might not balance the costs related to alternative programs. Programs for the aging are likely to encounter increased competition for limited funds in government budgets. A political issue of some importance could be associated with the allocation of funds among the different programs, given the number of governments and governmental departments and agencies involved.

An additional issue for consideration concerns the adequacy of professional and non-professional manpower. Providing and maintaining appropriate educational and training facilities, and meeting the associated costs of these, as well as ensuring fair distribution of manpower resources to enable the system to respond effectively to the needs of the aging, regardless of their location, are central to the manpower issue. These matters are discussed in the section on research and education. Not to be overlooked, however, is the contribution of volunteers, including senior citizens working with their peers.

INVOLVEMENT OF THE AGING IN PLANNING

Pressures to develop methods and procedures to involve the aging in the development of policies, and in the planning, organizing and delivery aspects of programs and services for the use and benefit of the aging are emerging; these can be expected to intensify.

Generally speaking, income support and service programs have been designed by others with little opportunity given to the aging to express their needs or aspirations. The aging population is heterogeneous in nature, it is made up of rural and urban residents and includes Native peoples, racial and ethnic minorities, migrants and refugees. These characteristics add to the diversity and complexity of the lifestyles, needs, and attitudes and values of the aging.

Despite the fact that they are bound together by the common element of advancing years, the aging can seldom be treated as a homogeneous group. The development of policies and the implementation of programs responsive to the needs of this diverse group can best be achieved through continuing involvement of the aging themselves.

CO-ORDINATION

Issues relating to aging are of concern at all jurisdictional levels: local, community, regional, provincial/territorial, national and international. Implicit in the increasing interrelationships and interdependence between societies and governments is the recognition that demographic patterns and socio-economic developments in one jurisdiction will have a significant impact on other jurisdictions. Effective communication, planning, and co-ordination between jurisdictions could improve essential planning and implementation of programs related to aging.

Building co-operation among governments at all levels and between governments and non-governmental bodies could offer the means whereby planning and policy formulation, allocation of resources, and management and delivery of services to meet the needs of an aging population could be more effectively balanced with the needs of the total society. Providing aged persons with more opportunities to participate, that is, sanctioning and expanding present involvement, could have a positive effect.

Problems of fragmentation, waste and duplication are likely when different levels of government as well as non-governmental agencies are all involved in the development and operation of programs and services that directly and/or indirectly affect the aged. Developing effective co-ordinating mechanisms in order to improve the use of resources, both human and economic, provide better services, both qualitatively and quantitatively, and strengthen the overall effort, represents an on-going political challenge.

Task forces, at the policy making level, organized on an intergovernmental or intragovernmental basis, or between governmental and non-governmental bodies, as appropriate, offer one possible method in the co-ordinating process. Focal points within jurisdictional levels in Canada could provide leadership therein in regard to the evaluation of various systems with a view to identifying strengths and weaknesses, duplication of effort, and like matters; identification of unmet needs; as well as education, training, and research needs respecting aging. Linkage between the focal points could provide a network for the exchange of information and the development of co-ordinating mechanisms for presentation to policy makers with suggestions for action.

Jurisdictional focal points might also direct their attention towards reaching some agreement regarding concepts, definitions, and data needs concerning the aging population. These efforts could be further enhanced by the development and maintenance of communication mechanisms for the collection and dissemination of information to support the work of policy makers, educators, and researchers inside Canada, and to further the collection, exchange and comparison of data at the international level.

AGE-INTEGRATED VERSUS AGE-SPECIFIC POLICY

Society has taken action for various reasons to provide age-specific programs, sometimes as a direct result of the expressed wishes of some older persons, e.g., senior drop-in-centres and club houses. Some of the programs have been directed towards meeting specialized needs such as housing developments for the aged.

Although the majority of older persons express the desire to remain in the "open community" in an age-integrated society, there are those who show a preference for age-specific programs. Not infrequently the latter are perceived by some as "ghettos" and the fear is expressed that those who patronize an age-specific program are segregated from society. If, for example, limited economic resources force an older person to live in age-specific housing because no other option is available, the charge of segregation could have some validity. In the final analysis, however, the issue is whether or not society is prepared to continue to provide or increase sufficient options to allow the aged person to exercise some measure of choice.

DEPENDENCY RATIOS

Lack of new and more sophisticated methods to measure economic dependency to aid in projecting the costs of funding programs of various types could continue to hamper policy makers. Once appropriate dependency ratios have been established, arriving at their national acceptance poses an issue that would entail political decisions.

ACTION PLANS

Establishing action plans locally, provincially and nationally, with target dates for accomplishment could represent an important mechanism in meeting the needs of an aging society, planning in advance of "the waves" of demographic changes, and co-operating with the United Nations, its associate organizations, and with other nations to advance the appropriate action plans among and between nations. Involving older citizens in furthering such endeavours could represent a most important aspect in ensuring the success of action plans.

HUMAN RIGHTS

The Charter of Rights in the Canadian Constitution, and existing human rights legislation across Canada, provide varying degrees of protection against discrimination on the basis of age. Studies and legislative reviews may need to be considered and developed to determine the future needs of an aging society that might best be addressed and protected through further legislation.

Legislation does not always meet the immediate or specific needs created by changing societal issues. It does, however, set the tone whereby regulations and policies may be established to meet evolving issues. The effect that this could have on society as a whole, whether direct or indirect, could represent a political issue.

RESEARCH AND EDUCATION

RESEARCH AND EDUCATION

RESEARCH

Certain age groups in Canada are growing at a rate faster than other age groups. The number of persons aged 60 and over is expected to increase from 3.2 million to 4.5 million by the turn of the century; the aged 80 and over group is expected to double before the year 2005. It is axiomatic, therefore, that data should be available to provide the information essential in dealing with the problems and issues that will arise as a result of the aging population. Herein lies the challenge regarding research.

Research in aging, whether fundamental or applied, has only recently been classed among the priority areas. Funding has been limited, but both governments and non-governmental bodies have been involved. Included in the latter are organizations such as the Canadian Geriatrics Research Society and a number of the larger charitable foundations. Research is being conducted in the universities and by private researchers, and is being encouraged by organizations such as the Canadian Association on Gerontology and its several provincial counterparts.

Gerontology is the scientific study of aging in all its aspects, including the clinical study and treatment of disease in old age (geriatrics). The field of gerontology is wide and varied. It involves many disciplines including anthropology, biochemistry, biology, economics, clinical medicine, nutrition, physiology, political science, psychology, and sociology. The conduct of reliable research is dependent upon trained manpower, adequate and secure financing, and an effective communication system between researchers. Mechanisms for the dissemination of the research findings to potential users are also necessary.

Policy Research

Research to aid in the development of policies and programs is conducted by governments and by non-governmental organizations concerned in a variety of ways with social issues. Governments usually undertake research for their own purposes using in-house resources, although in some instances research projects may be contracted to private consultants, consulting firms, or academic institutions when particular kinds of expertise are needed.

Policy research embraces both planning and evaluation. The tendency to assume that the latter is included, when in fact it is frequently ignored, led to a conscious decision to discuss planning and evaluation separately.

"Policy planning" is the term used to define goals and objectives for potential policies or programs, to design and develop policy and program options, and to effect the implementation of policies or programs. Policy planning tends to be future-oriented.

The relevance and usefulness of social policy research depends upon a number of factors including the timeliness of the study; precision in the statement of objectives; clarity of the hypothesis to be tested; adequacy of the research design, methodology, sample and data collection process; the skill with which the findings are interpreted; and comparison of the results to similar studies. The results of policy research do not always directly affect the process of policy development. For example, they may be used to inform managers about different aspects of program design, inputs and outputs. It is also important to note that research is only one of the many inputs in policy formation. Further, various actors are involved with different roles, views, attitudes and interests which have to be reconciled. Finally, the results of research have to be further refined and evaluated in a political process that involves bargaining, compromise and trade-offs.

Most government departments responsible for social policy and programs in the various jurisdictions in Canada have established research branches which plan and evaluate programs and policies. Research may be conducted in-house, or through contract research. Examples of policy research include surveys of Canada Pension Plan (CPP) survivors and CPP and Old Age Security beneficiaries, as well as the evaluation of the standards of quality in prescription and non-prescription drugs conducted by the Department of National Health and Welfare; studies of the needs of elderly persons by Manitoba, Prince Edward Island and Newfoundland; and an ad hoc evaluation of persons in "centres d'hébergement" and in "centres hospitaliers soins prolongés" in Quebec. Federal government departments and agencies are setting up systems for the evaluation of policies and programs with the assistance of the Office of the Comptroller General of Canada.

Program evaluation is undertaken to assess the effectiveness and efficiency of programs by measuring the extent to which they meet established goals and objectives, and to identify gaps and deficiencies in benefits and/or services delivered. The results of program evaluation are in turn presented to policy makers for action. In this way, program evaluation produces results which may be used as inputs to subsequent policy planning processes.

Policy evaluation is used as an important management tool to assess accountability of programs, and to ensure that they are adequately delivering benefits and/or services to program clientele. Over the years, pressures for setting up accountability measures have been building up within all levels of government.

Developing an Adequate Data Base

The development of good policies and programs depends upon good research. This in turn is dependent upon a reliable data base. In developing such a base, the kinds of data planned for and collected determine the nature and quality of the policy research that is possible.

Several agencies of the federal and provincial governments generate data used to analyse the social and economic conditions of key population groups and the services that are intended to serve them. The work of

Statistics Canada is especially notable. Surveys of the Labour Force, Consumer Finance, Household Facilities and Equipment, and others, provide data on the income, housing, work, and health of different age groups. Statistics Canada also authorizes the collection of data by other federal agencies and provides technical assistance to them when needed.

Statistics Canada has recognized that while data sources such as those just outlined provide a substantial basis for the comparative assessment of the conditions of different population groups as defined in terms of age and other attributes, especially at the national level, they were not originally designed to facilitate detailed analysis of needs, service utilization, and service performance with special regard to the older population. Statistics Canada is now taking steps to assess requirements for new data and analyses that focus on this particular population segment.

Research to provide data relevant to aging is also needed in other areas, for example, in the development of new measures of dependency that take into account factors other than age. The 1981 *Report of the North American Regional Technical Meeting on Aging*, prepared in relation to the World Assembly on Aging, in discussing dependency rates said: "Valid dependency rates cannot be defined solely on the basis of numbers of people at particular ages; economic activity needs to be taken into account, as well."

Governments need to assign increased priority to the task of developing adequate capability to deliver data needed by analysts to support policy making, program design, program implementation and program evaluation in the field of public services heavily utilized by the older population. There has been a proliferation of relevant service programs at each level of government in several countries but with very few exceptions, such as Sweden and the Netherlands, most countries seem to have assigned low priority to the task of securing that capability (a task henceforth referred to as "information infrastructure development"). If this condition persists, countries will not be able to demonstrate ways to avoid waste in the use of public resources devoted to services used mostly by the aged because their analysts will be unable to conduct adequate assessments of the effectiveness and efficiency of the services.

The foregoing assessment is based partly upon two studies, one completed and one still underway, sponsored by Statistics Canada. These studies have been undertaken because evidence points strongly to the conclusion that social problems, public policy making, and services relating to Canada's senior citizens comprise an area of major growth in demand for useful information during the next two decades, and that if Statistics Canada is to fulfil its legislated mandate it must prepare itself to work effectively with other agencies that will be called upon to meet the important demands in this area. The completed study, done by an interdepartmental committee, was designed to identify departmental needs for the improvement of social indicators relating to aspects of Canada's "population aging". The study that is underway, co-sponsored with the Department of National Health and Welfare, is designed to help Statistics Canada anticipate the kinds of information innovations that will be needed in the 1980s if important demands by a variety of analysts across the country are to be met with regard to data about needs for services, usage of services, and availability and performance of services by and for Canada's older population. This study involves consultations (partially completed) with groups of regional experts in gerontology as well as a survey (completed) of the kinds of relevant data that have been published in Sweden, Great Britain, the United States of America, France, the Netherlands, the Federal Republic of Germany, and Finland. (All of these countries have higher proportions of aged persons in their populations than does Canada.)

Relevant lessons that have been learned from these studies may be summarized as follows:

- At present, the capability to deliver data, usable in various analyses aimed at answering important questions pertaining to services for the aging, is well developed mainly in the areas of expenditures by service delivery organizations or the volumes of different kinds of inputs (e.g., beds, nurses' hours) and outputs (e.g., patients discharged, clients consulted, meals served) of such organizations. There is, however, great variation among classes of organization with regard to the adequacy of such data. A few classes of relevant organizations, notably acute care hospitals, gather data about some attributes of their clients. Even among such organizations, however, the data on amounts of different types of input applied to particular categories of clients are extremely fragmentary.

- Among different jurisdictions, such as the provinces of Canada, there is great variation with regard to statistical concepts and other conventions relating to the same kind of organization or service.

- Data aimed at tapping dimensions of the effects of delivered services on clients' welfare are seldom gathered.

- Equally scarce are pertinent data on the population from which clients are drawn, and these are data needed to assess what types of people are using available services at unusually high or low rates.

- Even more scanty are data that reveal the numbers of older persons with different degrees of particular disabilities.

Questions concerning important dimensions of the effectiveness of services, in terms of pertinent aspects of their impact on the population, as well as those that relate to the efficiency of services, in terms of the optimum mix of service inputs applied to different categories of clients, cannot be adequately answered in the present state of information infrastructure development. Yet these are precisely the classes of question that need to be addressed if the pattern of expenditure of resources over a whole spectrum of services is to be rationalized to avoid waste.

Issues surrounding the future allocation of scarce resources may give rise to questions regarding the rationality with which funds are allocated across the spectra of relevant programs designed to deliver services that are heavily consumed by the aging. The adequacy of the existing information infrastructure will become a crucial matter in arriving at equitable solutions.

Federal Government Support of Research

Various federal departments and agencies have examined the issues related to aging and have taken action to conduct or support research.

The Social Sciences and Humanities Research Council of Canada supports and encourages scientific research primarily in universities. Under a strategic grants program inaugurated in 1979, population aging was one of the three areas identified for funding. In 1980, strategic grants funded projects, fellowships, and workshops relative to aging to the extent of $600,000. Emphasis is placed on the investigation of the short- and long-term effects of population aging on education, economics, retirement, culture, leisure, communications, health, housing and transportation as well as on social and political attitudes. In addition, the council has supported the development of two research centres - one at the University of Manitoba and one at Simon Fraser University. These centres are expected to provide a strong stimulus for increased research, particularly of a multidisciplinary nature, and will be focal points for teaching and community services.

The Medical Research Council supports and encourages scientific research including some research on aging. Awards have been given for geriatric and gerontological research as well as for fundamental research that has implications for understanding the aging process. The council intends to sponsor a national conference on pharmacology relative to older persons, possibly in the fall of 1982.

The Science Council of Canada has recognized that the changing age structure in Canada has implications for many kinds of policy. It has produced reports such as: Perceptions 1: Population Growth and Urban Problems, 1975 and Perceptions 2: Implications of the Changing Age Structure of the Canadian Population, 1976 and Report No. 25 Population, Technology and Resources, 1976.

The Canada Mortgage and Housing Corporation, as part of its housing mandate, conducts and supports housing research. Several studies have resulted in a comprehensive set of building standards dealing with housing for elderly persons to be used by designers and builders of facilities to be occupied by the aging. The standards are grouped for three levels of need: private residential buildings with single family units, homes for special care for the aging*, and chronic care facilities. These studies have also led to the development of a new program, called the Social Housing Program, which will subsidize the building of housing for the aged and the handicapped.

The Department of National Health and Welfare supports research and demonstration projects, some of which are related to aged persons. Through its Welfare Grants program, the aged have been identified as one priority group where emphasis is needed concerning increased research and service development. Some of the areas covered include self-help networks, community responsiveness to isolated older persons, and the facilitation of consumer involvement in social policy. Current expenditures constitute eight per cent of the present $3.5 million budget. Additional funds have been requested to increase funding under Welfare Grants.

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* See footnote p. 64 and "Institutional Care", p. 100.

The National Health Research and Development Program operated by the Department of National Health and Welfare funds research, demonstration projects and research training in priority areas that include the disabled and handicapped, health care systems for aged persons, and illness prevention. Currently five per cent of funded projects, totalling $9 million in 1981, pertain directly to aged persons or aging and another 10 per cent pertain indirectly to the older age group.

Health promotion has become a priority for the Department of National Health and Welfare. Projects have been funded to increase the capacity of Canadians to enhance and maintain their good health, to avoid health risks and to manage with chronic and disabling conditions by themselves. These projects seek to demonstrate the effectiveness of health promotion and illness prevention programs. Priority is given to six population groups, including the aged, and focus on six issues - tobacco, alcohol and drug use, nutrition, safety, and mental health. In consequence, some major health concerns associated with aged persons and aging are covered. In 1981-82, approximately five per cent of the health promotion budget of $2.1 million was for projects related to aged persons.

Provincial Government Support of Research

Most provincial governments either conduct policy research internally in support of their mandates or commission or contract research for this purpose. Some of the provinces support research extramurally, either related to their functions, or related to more general issues in the health, welfare or income security fields as these pertain to the aging.

In the area of data collection, the Department of National Health and Welfare has made arrangements with the provinces to collate data from administrative sources, thereby allowing the portrayal of national and provincial patterns of usage, operations and expenditures on such services as hospitals and long-term care institutions. The department also, through contributions to the provinces, is assisting them in the improvement of management information systems for social services. These data files provide information useful for research on problems related to aged persons.

Some provinces have bodies that provide financial support to scientific research. In most cases the research funded is not specific to the aging, but projects include research on aging and deal with matters pertaining to aged persons.

The British Columbia Health Research Foundation funds scientific health research; some of the projects funded are related indirectly to gerontology. The Alberta Heritage Foundation for Medical Research funds research in the clinical/medical field, with some of this research being directed to the aging. Included is research on cardiac problems, visual disturbances in aging, and neurological disturbances that inhibit proper response. A seminar for Research in Gerontology in Alberta was held in June 1980 sponsored by the Alberta Council on Aging and the Senior Citizens Bureau. At the annual meeting of the Alberta Association on Gerontology in June 1981, several papers on gerontological research were presented.

In Saskatchewan, the Saskatchewan Health Research Board provides research grants on health related topics, and the Saskatchewan Research Council covers all areas of research including aging. The province has been generous in its support of research carried out by the Geriatric Assessment Unit of the Division of Geriatric Medicine in the College of Medicine, University of Saskatchewan in Saskatoon, as well as for studies carried out by the research staff of the Senior Citizens' Provincial Council.

The Manitoba Health Research Council considers research proposals dealing with aging and issues concerning aged persons. In Ontario, the Gerontology Research Council of Ontario, set up in January 1980, finances research in gerontology using funds made available by the Government of Ontario. In its first year of operation, the council decided that priority should be given to research/fellowship/scholarship/personnel support projects, and six were funded in 1981-82. Funding from other Ontario agencies covers age-related studies in nutrition and mental health. As of January 1982, the Ontario Seniors Secretariat has a mandate to co-ordinate research conducted through the provincial ministries in the social development policy field.

The Quebec Social Research Council attached to the Department of Social Affairs funds research projects in gerontology. Two gerontological laboratories located in Laval University, Quebec City, and in the University of Quebec at Three Rivers, study problems in social gerontology and provide support to researchers.

Future Needs for Research

While research in aging is being conducted, contracted out and funded by governments, much needs to be done in the future. All governments will face budget restrictions which will involve the research sector of their operations. Yet, if problems are to be resolved and issues are to be properly addressed, the contribution that research can make is extremely important. The importance of this contribution must be conveyed to the decision makers. Those responsible for research in governments will have to strive to improve the quality of research, and to ensure that the best possible research is being delivered at the least possible cost. Some issues will need to be examined using a longitudinal framework which is costly, but which may result in economies from better designed policies and programs. An evident need is for the co-ordination of research among the different governmental jurisdictions so that research on certain issues and problems is not duplicated. In supporting gerontological and geriatric research in the private sector, governments providing funds will need to establish plans of action and set priorities for the kinds of research projects to be funded.

EDUCATION

Concern in this section is directed towards the education of personnel about aging and the aged. It is multidisciplinary in scope. The education of teachers with the necessary knowledge and skills to train professional personnel as planners, administrators, and researchers, and both professional and auxiliary personnel to serve as care givers is of foremost importance. Education of the general public about aging, and meeting the educational interests of the aged as a group are dealt with in the section on education/culture/recreation.

Current Situation

Currently, the education of those serving aged persons is improving over what it was in former years. There is evidence that this situation will continue to improve in the future. Many universities are offering courses on different aspects of gerontology at the graduate and undergraduate levels in various professional schools and in several disciplines; a number of universities are offering certificates or diplomas in gerontology. Many medical schools in Canada now have departments or co-ordinators of geriatric medicine. Several provinces provide education to practising professionals working in the field. For example, New Brunswick provides funding to physicians for further training in geriatrics; Saskatchewan sponsors visits by distinguished persons and visiting lecturers, and provides bursaries for training in geriatric medicine and nursing, and a one month's residency program for physicians in practice; and Alberta provides bursaries for short-term studies in geriatrics by doctors.

In a number of provinces, education is provided at the community college level and in Quebec at 11 Collèges d'enseignement général et professionnel (CEGEP) for the training of special workers who care for aged persons at home and in institutions such as homemakers, health aides, special care aides and other such workers. In other provinces, training of these workers may be carried out by private organizations; in New Brunswick, for example, the Red Cross has well defined programs for homemakers and friendly visitors.

Simon Fraser University in British Columbia is offering a diploma in gerontology commencing September 1982, and is planning to offer a master's degree in this subject. Manitoba has a well developed program at the community college level which provides a certificate in gerontology. Ryerson Polytechnical Institute in Toronto offers an interdisciplinary certificate in gerontology, the University of Manitoba an advanced certificate in gerontology, and the University of Toronto a graduate diploma in gerontology. There are course offerings in geriatrics and gerontology at other Ontario universities and colleges. In Quebec, at the university level, for example at the Universities of Montreal, Laval, and Quebec at Chicoutimi, there are eight programs leading to a certificate in gerontology. Mount St. Vincent University in Nova Scotia offers a certificate in gerontology.

The foregoing educational programs are offered to professionals who are currently working in the field of aging. They include administrators, nurses, physicians, and social workers. Mention should also be made of the Office on Aging at McMaster University which provides a focal point for education and research on aging in that institution.

Programs in the special care of aged persons are offered on an in-service training basis to personnel. The Province of Alberta supports such training by underwriting workshops for persons working in nursing homes and senior centres, and by assisting those responsible for in-service training in nursing homes. In Saskatchewan, the Department of Continuing Education has developed the Home Care Service Program which is an in-service program for all providers of care, and the Special Care Aide Program which is an in-service training course for aides working in special care homes. Government funds are used by the Nursing Home Association in Saskatchewan for in-service training of staff.

Health teaching and health counselling of families who care for their aged members and of aged persons receiving care are provided by public health nurses, community health nurses and by organizations such as the Victorian Order of Nurses. The Province of Alberta has developed a resource kit on understanding and working with older persons which could be used by families caring for their elderly members. Alberta has sponsored pilot discussion groups in Edmonton and Calgary for adult children who care for older family members.

The Province of Alberta provides education grants to individuals and to finance workshops in order to increase skills and knowledge about aging and older persons. An innovative program started in Saskatchewan called the "Train the Trainers" program involves training group leaders, including older persons, to organize and conduct physical fitness programs for older adults.

Universities in Canada prepare professionals in many disciplines for careers in research, some of whom will engage in research on aging. Because universities are beginning to offer more courses in gerontology, undergraduates and graduates preparing for research careers can supplement the courses required by their respective disciplines with courses in gerontology and/or geriatrics.

Several organizations in Canada provide funding for training researchers in gerontological research. One of these is the Gerontology Research Council of Ontario which is currently providing funds for research fellowships and scholarships. The Social Sciences and Humanities Research Council of Canada makes available post-doctoral awards to assist scholars to undertake research or to specialize in any aspect of the aging population. The National Health Research and Development Program of the Department of National Health and Welfare makes available five-year awards for National Health Scientists and National Health Research Scholars to participate in research and to act as educators. Among the scholars supported by this program are several persons in Canada who have become prominent as researchers and educators in gerontology.

Future Needs for Education

Training and education about aging and the the aged is only in developmental stages in Canada. There is no organized or established system, but rather a series of initiatives in a number of areas covering different aspects of training and education. Initiatives taken have been stronger and more developed in some provinces, as well as in some aspects regarding aging, than in others. Some facets of education and training are either not covered or dealt with in a rather fragmentary fashion.

If the necessary supply of trained manpower, appropriately trained to meet established standards, is to become available, a number of issues have to be dealt with. One such issue is to determine the kinds of manpower that will be needed to provide health and social services to aged persons and the probable numbers required. As needs change over time as a result of changes in the economic, social and political structures, studies will be needed to assess the nature of the prospective needs of older persons and to estimate the numbers and the different kinds of manpower required in respect to these projected needs. Following such assessment, planning to meet the manpower requirements will have to be initiated as soon as possible so that the personnel will be available when required. Inherent in the determination of manpower needs is the requirement for teachers and researchers; governments, academic institutions and non-governmental bodies will all require both educators and research personnel.

Another issue of importance is the determination by governments of their role in ensuring the adequacy of future manpower requirements. This role could be limited to estimating the needed manpower supply. It could, however, be broadened to include active planning and involvement in facilitating, motivating, and encouraging both the necessary changes to the educational structures and in career development in aging.

APPENDIX
Provincial/Territorial
Governmental Programs and Systems
1982

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
ADVISORY AND CONSULTATIVE MECHANISMS												
COUNCILS AND COMMISSIONS		Provincial Senior Citizens Advisory Council(3)	Sask. Senior Citizens' Provincial Council(3)	Man. Council on Aging(1)	Ont. Advisory Council on Senior Citizens(4)			N.S. Senior Citizens' Commission(3)				
DEPART-MENTAL OFFICES AND CONSULTANTS	Consultants in Gerontology & Geriatrics(3)	Senior Citizens Bureau(3)	Provincial Gerontologist(3)	Provincial Gerontologist (3) Services to Seniors, Dept. of Health(3)		Policy Services to Adults and Senior Citizens, Dept. of Social Affairs(1,3)	Community Based Services for Seniors, Dept. of Social Services(3)		Division of Services to the Aging, Dept. of Social Services(4)	Division of Services to Senior Citizens, Dept. of Social Services(4)		
INTERDEPART-MENTAL CO-ORDINA-TION		Interdepartmental Co-ordinating Committee on Senior Citizens(3) Planning Committee on Programs/ Services for Older Persons*(3)	Interdepartmental Task Force(3)	Council Liaison Officers(3)	Ont. Seniors Secretariat(4)			N.S. Senior Citizens' Secretariat(3)				
COMMUNITY SUPPORT												
COMMUNITY HEALTH SERVICES	Community Physiotherapy Services(1) Public Health Nursing(1) Special Care Services (rural)(1)	Community Health Nursing Program(1) -Health Information & Counselling in Senior Centres(3) -Home Visiting(1)	Community Health Services(1) Senior Citizen Neighbourhood Health Centres(3)	Public Health Nursing Services(1)	Health Units(1) Homemakers & Nurses Services(1,11)	Local Community Service Centres (1) Nurses Services (1) Physical Fitness: "Kino-Québec"(3)	Public Health Nursing(1) Senior Citizen Clinics (rural)(3)	Community Health Nursing(1) Community Health Services(1) Community Nutrition Services(1)	Audiology Program(1) Occupational Therapy(1) Physiotherapy(1) Public Health Nursing Program(1) Speech Therapy(1)	Home Care Program -Public Health Nurses or VON(1) Occupational Therapy(1) Physiotherapy(1)		Co-ordinated Home Care Program -Home Nursing Services(1,11) -Other Professional Services(1,11)
COMMUNITY SOCIAL SERVICES**	Community Human Resources & Health Centres(1) Death & Dying Counselling (1) Family Counselling (1) Home Repair Services(3) Legal Aid(1,10) Seniors' Counsellor Program(3) Skills Exchange (3)	Family & Community Support Services -Home Help(1) -Homemaker Services(1) -Meals-on-Wheels (1) -"Outreach" Services(1)	Community Services (grants)(1) Home Care Services -Handyman Service(1,11) -Meals-on-Wheels (1,11) -Nursing(1) Seniors Assisting Seniors(3)	Age & Opportunity Centre, Inc.(4) Daily Hello(3) Home Economists(1) Legal Aid Man. (1,10) Meals-on-Wheels (1,11) Services to Seniors(3)	Home Handyhelp Programs(4,11) Intergenerational Programs(4) Legal Aid Ont. (1,10) Link Skills Exchange(6) Meals-on-Wheels, Diners' Clubs (4,11) Other Home Support Projects (4,11) Senior Volunteers in Service(6)	Legal Aid(1,10) Support Program for Voluntary Organizations (1) -Meals-on-Wheels (1,11)	Community Based Services for Seniors(3) Friendly Visiting to Seniors (Red Cross)(3) Protection Services to Seniors(3)	Friendly Visiting (Red Cross)(3) Legal Aid Program (1,10) Meals-on-Wheels (1,11) Wheels-to-Meals (1,11)	Provision of Personal Services(4)	Community Based Services -Crime Prevention(4) -Friendly Visiting(4) -Meals-on-Wheels (4) -Volunteer Centre in St. John's(4) -Wheels-to-Meals (4) Social Services(1)	Services for Seniors(3)	Co-ordinated Home Care Program -Meals-on-Wheels (1,11) -Neighbourhood Services(1,11)

* Department of Hospitals and Medical Care and Department of Social Services and Community Health.

** Including meals-on-wheels, counselling, friendly visiting, senior volunteers, legal aid.

NUMERICAL KEY

1. Total general population
2. Special group (e.g.,handicapped)
3. Aged 65 and over
4. Aged 60 and over
5. Aged 60 to aged 64
6. Aged 55 and over
7. Aged 45 and over
8. Adult to aged 64
9. Widowed persons who meet certain stated conditions
10. Income or needs tested
11. Fee for some services
12. No fee for aged 65 and over
13. No fee for aged 65 and over and dependants

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

COMMUNITY SUPPORT (Cont.)

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
DAY CARE SERVICES	Long-term Care Program -Adult Day Care(1,11)	One Service in Edmonton(6)	Senior Care Centres(3)	Continuing Care Program (Home Care) -Adult Day Care(1,11)	Adult Day Care (6,11) Respite Care (4,11)	Day Care Centres(1)	Adult Day Care in Community Setting(1) Day Care Programs in Nursing Homes (3)		Day Centre at Brecken House (4) Day Programs at Other Homes for the Aged(4)	Day Programs at Senior Citizens' Homes (limited) (4)	Day Care Program at Lodges(3)	
HOME CARE/ SUPPORT SERVICES	Long-term Care Program -Home Care Services(1,11) -Homemaker Services(1,11)	Co-ordinated Home Care Program -Nursing(1,11) -Rehabilitation (1,11) -Support Services(1,11)	Home Care Services -Homemaking(1,11) -Nursing(1,11)	Continuing Care Program (Home Care) -Homemaking(1) -Home Therapy (via Community Therapy Services)(1) -Nursing (via Community or VON)(1) -Respite Care (1)	Acute Home Care(1) Chronic Home Care(1) Homemakers & Nurses Services (1,11) Home Support Projects(4,11) Institutional Home Care(1) Respite/ Vacation Care (4,11)	Home Care Program(1) Homemaker Services(1)	Community Based Services for Seniors(3) Extra-mural Hospital Program(6) Long-term Home Care Program(3) Short-term Home Care Program(1)	Home Care Demonstration Projects(1,11) Homemaker Services(1,11)	Home Care Program(1) Homemaker Services(1,11)	Home Care Program(1) Homemaker Services(1,11) Respite Care (limited)(1)	Respite Care(1)	Co-ordinated Home Care Program(1,11)
SENIOR CITIZEN CENTRES AND GROUPS*	Senior Citizen Centres(3)	Alta. Council on Aging(3) Facility Grant Program(3) Family & Community Support Services -Grants to 35 Senior Centres (3)	415 Senior Activity Centres(6) Senior Citizens' Groups(grants)(3)	Age & Opportunity Centre, Inc. (7 centres)(4) Brandon Civic Senior Citizens Inc.(4) Selkirk Seniors Centre(4) Services to Seniors(4)	Elderly Persons' Centres(6,11) Leadership Training Programs(6,11) Senior Citizens' Clubs(6)	Community Centres for the Retired & Pre-retired(3)	Senior Citizen Centres(3)	Continuing Education Services(3)		District Service Councils(4) Nfld. & Labrador Association for the Aging(4) Nfld. & Labrador Pensioners & Senior Citizens Federation(4)	2 Senior Centres(3)	
TRANSPOR-TATION SERVICES	Free B.C. Ferry Service(3) Free Driver Exam(3) Handy-Dart, Individual Transport Program(2) Reduced Licence Fees(3,11) Reduced Metro. Transit Fees (3,11) Subsidized Bus Pass Program (3,10)	Minimal Fee Bus Passes(some centres)(3,11) Special Transportation Services for Elderly and Handicapped Persons (grants)(2,3)	Community Transportation Services (grants)(2,3) Discounted Travel Fares for Seniors (3,11) Handicapped Transit Assistance(2) Senior Driver Program(3) Transit for the Disabled(2)	Handi-Transit (Winnipeg & Brandon)(2) Program of Transportation of Handicapped Persons in Rural Man.(2) Winnipeg Metro. Transit Discounts(3,11)	Reduced Transit Fees (Metro.Toronto & other centres) (3,11) Wheel Trans-Services/Buses for Disabled & Elderly Persons(2,3,11)	Reduced Transit Fares for Senior Citizens (Montreal & Quebec)(3,11) Special Public Transportation (7 urban centres)(2,3)	Municipal Services for Elderly & Handicapped Persons (Fredericton) (2,3) Reduced Fares on Public Transit(3,11)	Bus Fare Discount (Halifax)(3,11) Free Dartmouth Ferry(3)		Special Transportation Services(4)	Handy Bus Program(2,3) Reduced Transit Fares (Whitehorse) (3,11)	

* Including grants and consulting services.

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
						ECONOMIC SUPPORT						
INCOME SUPPLEMENTS	Guaranteed Available Income for Need(GAIN) for the Handicapped (2,10) GAIN for Seniors(4,10) GAIN Supplement (3,10)	Alta. Assured Income Plan (3,10) Assured Income for the Severely Handicapped (2,10)	Sask. Income Plan(3,10)	Man. Supplement for Pensioners (6,10)	Family Benefits -Guaranteed Annual Income System (GAINS)- Disabled(2,10) -Seniors(4,10) GAINS-Aged (3,10) Soldiers' Aid Commission(1,10)			Municipal Social Assistance(3,10) Special Social Assistance(3,10)				Senior Citizens' Benefits(3,10)
INSURANCE ASSISTANCE	Principal Residence Policy Program (discounts)(3) Senior Citizen Automobile Insurance Grant(3) Tenants' Package Program(3)		Pension Pak (insurance discounts) (3,10)	Discounts on Property Insurance & Insurance on Possessions(3)	Criminal Injuries Compensation (1)							
PUBLIC PENSION PLAN*						Quebec Pension Plan(1)						
RENT ASSISTANCE	Renters' Tax Credit(1,10) Rent Supplement (1,10) Shelter Aid for Elderly Renters(3,10)	Renter Assistance Credit(8,10) Renters' Assistance to Mobile Homeowners (3 & 5,9) Renters' Grants (3 & 5,9)		Shelter Allowances for Elderly Renters (6,10)	Rent-Geared-to-Income for Senior Citizens Program -Rent Supplement (4,10)	Housing Grant Program(3,10)	Rental Assistance for the Elderly (3,10)	Rental Assistance(4,10)		Social Assistance (1,10)		
SOCIAL ASSISTANCE	GAIN Program (1,10)	Social Allowance Program(1,10)	Sask. Assistance Plan(1,10)	Municipal Assistance (1,10) Social Allowances (1,10)	Family Benefits (1,10) General Welfare Assistance (1,10)	Social Aid (1,10)	Social Assistance (1,10)	Family Benefits (1,10) Municipal Social Assistance(1,10)	Welfare Assistance (1,10)	Social Assistance (1,10)	Social Assistance (1,10)	Social Assistance (1,10)
TAX PROVISIONS a) PROPERTY AND SCHOOL TAX ASSISTANCE**	Homeowner Grant (2,3) Land Tax Deferral Scheme(2,3)	Property Tax Rebate for Senior Citizen Homeowners (3 & 5,9) Property Tax Reduction(3)	Property Improvement Grant(1) Renters' Property Tax Rebate(1) Senior Citizens' School Tax Rebate(3)	Pensioners' School Tax Assistance(6) Property Tax Credit(1,10) Property Tax Deferral Program(3) Special Senior Credit(3)	General Property Tax Credit (8,10) Municipal Property Tax Aid(3) Ont. Seniors' Property Tax Grant(3)	Real Estate Tax Refund(1,10)		Property Tax Rebate(4,10)	Property Tax Deferral System(3)	Social Assistance (1,10)	Home Owners' Grant(1)	Home Owners' Property Tax Rebate(1) Property Tax Deferrals (3,10)

* All other provinces and territories are participants in the Canada Pension Plan.
** Renters and/or homeowners.

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
ECONOMIC SUPPORT (Cont.)												
(Cont.) b) OTHER TAX PROVISIONS	Political Contributions Tax Credit(1) Provincial Personal Income Tax Credit(1,10)	Political Contribution Tax Credit(1)	Low-Income Tax Reduction(1,10) Senior Citizens' Tax Reduction(3)	Cost of Living Tax Credit(1) Political Contribution Tax Credit(1)	Ont. Retail Sales Tax Grant(3) Political Contribution Tax Credit(1) Retail Sales Tax Credit(8,10)		Political Contributions Tax Credit(1)	Political Contributions Tax Credit(1)				
WORKERS' COMPENSATION	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workmen's Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)	Workers' Compensation(1)
EDUCATION AND RECREATION												
ADULT EDUCATION COURSES	Courses at Several Institutions(1) Knowledge Network (universities) (1) Nelson Summer University for Seniors (U. Victoria) (3)	Further Education Services -Non-credit Courses(3) -Sessions for Seniors at 2 Universities(3) Tuition Fees Waived at Post-secondary Institutions(3)	Most Tuition Fees Waived at 2 Universities & Community Colleges(3)	Elderhostel (4,11) English as a Second Language(1) Institute for Continuing Development in Retirement(3) Nominal or No Tuition Fees at Several Institutions (3,11)	Elderhostel (4,11) English as a Second Language(1) Free Correspondence Courses(1) Reduced or No Tuition Fees at Most Institutions (3,11)	Geriatrics & Gerontology Courses at Some CEGEPs & Universities (1)	Elderhostel (3,11) Free University Tuition(3) "Université du Troisième Âge" (U. of Moncton) (3)	Community School Programs(1) Elderhostel (3,11) Free University Tuition(3) Local School Board Programs (1)	Community School Programs(1) Elderhostel (U.P.E.I.)(3,11) Free University Tuition (U.P.E.I.)(4) Gerontology Courses at Holland College (1)	Nominal or No Tuition Fees at Several Institutions (4,11)		
INFORMATION SERVICES a) LIBRARY AND RESOURCE SERVICES	Large Print Books, Talking Books, Bookmobile(1) Publications Available(1)	Large Print Material, Talking Books, Home Delivery of Books(1)	Large Print Material, Talking Books(1) Workshops for Librarians on Needs of Seniors (1)	Public Library Services(1) -Grants, Large Print Material, Talking Books, etc.	Public Library Services(1) -Grants, Large Print Material, Talking Books, etc.	Municipal Library Depots in Day Care Centres(1)			Resource Materials Available(1)	Free Library Shut-in Services(2,4)		
b) OTHER INFORMATION SERVICES*	Consumer Counselling(1) Financial Planning & Investment Consultation(1) Pre-retirement Planning(1) Zenith Information Lines(1)	Consumer Help(1) Local Information Services for Seniors(3) Pre-retirement Programs(1) Senior Citizens Bureau(3)	Pre-retirement Programs(1)	Consumer Assistance & Translated Series for Consumer Protection(1) Home Economics Information(1) Income Tax Service(3) Pre-retirement Planning for Rural Residents (1) Seniors' Hour, TV(3)	Community Information Centres(1) Leadership Training -Seniors' Clubs & Retirement (6,11) Radio Open College Programs(1,11) Retirement Literature(1,11) TV Ontario(1)	"Communication-Québec" -Information & Reference Services(1) Retirement Preparation Courses(1)	Financial Planning(1) Information Services to Seniors(3) Pre-retirement Counselling(1)	Consumer Information(1) Continuing Education Services(1) Pre-retirement Seminars(1)	Community Awareness Programs(1) Pre-retirement Seminars(1)		Pre-retirement Counselling(1)	

* Including pre-retirement counselling.

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
EDUCATION AND RECREATION (Cont.)												
RECREATION PROGRAMS AND SERVICES	Camping Subsidy (2,3) Hunting & Angling Licences for Senior Citizens (3) Recreation Programs(3) Sports Events(3)	Consulting Services(4) Keepsake Readers' Theatre Program(1) Local Recreation Services including 2 Senior Recreation Centres(3) Senior Citizens' Sports & Recreation Association(3) Senior Summer Games(3)	Community Recreation Grants(1) Free Entry to Provincial Parks, Recreation Sites, & Trans-Canada Campgrounds(3) Free Fishing Licences(3) Golden Green Tours of Provincial Parks(3) Reduced Golf Permit Rates(3)	Free Access to, & Camping in, Provincial Parks(3) Free Fishing & Gamebird Licensing(3) Guided Tours (2,3) Recreation Program Development(1) Reduced Golf Fees (3)	Community Recreation Grants(1) "A Guide to Travel in Ont. For Seniors"(3) Leisure & the Older Adult(1) Ont. Senior Citizens' Privilege Card(3) Recreation Program Development (6,11) Reduced Fees to Provincial Parks, Galleries, Ont. Science Centre, etc. (3,11)	Aid to Senior Citizens' Programs in Outdoor Recreation Centres(3) Aid to Special Institutions(1) Aid to Vacation Camps(3) Discover Quebec Program(1) Free Camping in Certain Government Campgrounds(6) Vacation Resorts(6)	Free Entry to Provincial Parks(3) Special Swimming & Fitness Classes(3)	Improvements to Facilities -Little Red Schoolhouse Program & Regional Fitness Development Program(1) Information Program(1) Local Recreation Programs(1) Senior Citizens' Drama Club(3)		Fun & Fitness Program(Red Cross)(4) Recreation & Social Events(service clubs)(4) Reduced Golf Permit Rates (some areas)(4)		Community Recreation Programs(1) Grants to Organizations(1)
HEALTH												
AMBULANCE AND OTHER TRANSPORTATION SERVICES	B.C. Medical Services Plan(1)	Alta. Blue Cross Benefits (1,11,13)	Air Ambulance(1) Road Ambulance(1)	Northern Patient Transportation Program(1)	Ont. Health Insurance Plan(1,11,12)	Free Ambulance Services(3)	Ambulance Services (grants)(1)	Ambulance Services(1,11)		Air Ambulance(1) Road Ambulance(1)	Travel Assistance for Medical Treatment(1)	Travel Assistance for Medical Treatment(1)
DAY HOSPITAL SERVICES		4 Day Hospitals (1,11)	Day Hospitals(1)	Day Hospitals(1)	Day Hospitals(1) Geriatric Day Hospitals(2,3)	Day Hospitals (6 in Montreal, Quebec & Hull)(1)				Day Hospital (Miller Centre) (1)		Day Hospitals (1,11)
EXTENDED HEALTH BENEFITS*	Basic Health Care Services (4,10) Dental Care Plan (1,10 & 3,11) Hearing Aids & Speech & Hearing Program(1)	Extended Health Benefits Program (3,13) -Hearing Aids, Dental Care, Medical & Surgical Supplies, etc.	Health Benefits for Social Assistance Recipients(1,10) Sask. Aids to Independent Living(1) Sask. Hearing Aid Plan(1)	Medical Supplies & Home Care Equipment Program(1) Social Allowances (3,10)	General Welfare Assistance(1,10) Special Assistance to Seniors (3,10)	Social Aid -Special Needs(1,10)	Community Based Services for Seniors(3) Supplementary Health Coverage(1,10)	Home Oxygen Therapy Program (Metro.)(1) Sickroom Equipment Supply Program(1)	Financial Assistance Available for Special Equipment(1,10)	Sickroom Equipment Supply Program (Red Cross)(4) Social Assistance -Special Needs (1,10)	Social Assistance -Special Needs (1,10)	Co-ordinated Home Care Program -Equipment Loans(1)
GERIATRIC ASSESSMENT CENTRES	Geriatric Assessment & Treatment Centres(3)	Geriatric Assessment Centre (Edmonton)(3)	Geriatric Assessment Unit & Day Hospital (Saskatoon)(3)	Geriatric Assessment Units at Health Sciences Centre & Extended Treatment Units (3)	Geriatric & Psychogeriatric Assessment Units(2,3)					Geriatric Assessment & Day Hospital (Miller Centre) (1)		

* Including hearing aids, dental care, medical and surgical supplies and equipment.

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

HEALTH (Cont.)

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
HEALTH EDUCATION	Health Education Programs(1) Senior Chef, TV(3)	Health Education (1)	Health Education Programs(1)	Nutrition Counselling & Health Education(1)	Public Health Units(1) Red Cross-St. John Ambulance(1,11)	Health Education (1)	Health Education (1)	Health Promotion & Education(1)	Health Promotion & Education(1) Senior Chef, TV(4)	Health Education (1)		
MEDICAL AND HOSPITAL INSURANCE	B.C. Hospital Insurance(1,11) B.C. Medical Services Plan(1,11)	Alta. Health Care Insurance Plan (1,11,13)	Sask. Hospital Services Plan(1) Sask. Medicare(1)	Man. Health Services Insurance Plan(1)	Ont. Health Insurance Plan(1,11,12)	Que. Health Insurance Plan(1,11)	Extra-mural Hospital Program(1) N.B. Hospital Services(1) N.B. Medicare(1)	N.S. Hospital Insurance Program(1) N.S. Medical Services Insurance(1)	P.E.I. Health Services(1) P.E.I. Hospital Services(1)	Nfld. Hospital Insurance(1) Nfld. Medical Care Insurance (1)	Yukon Hospital Insurance Plan(1) Yukon Medicare Plan(1,13)	N.W.T. Health Care Plan(1)
MENTAL HEALTH SERVICES	Mental Health Services(1)	Regional Mental Health Clinics(1) 2 Alta. Hospitals(1)	Psychiatric Services(1)	Mental Health Services(1)	Mental Health Services(1) Psychogeriatric Units(3)	Psychogeriatric Services(3)	Mental Health Services including Clinics(1)	Psychogeriatric Services (N.S. Hospital)(3)	Community Mental Health Teams(1)	Mental Health Services(1)		
PLACEMENT AND REFERRAL SERVICES	Social Services, B.C. Hospitals (1)	Placement Services in 3 Urban Centres(1)		Continuing Care Program Assessment for Home Care & Placement(1)	Placement Co-ordination Services(1)	Social Service Centres(1)	Nursing Home Assessments(1)		Provision of Personal Services (4)	Social Services (1)	Seniors Placement Committee(3)	
PRESCRIPTION DRUG PLANS	Pharmacare (1,11; 1,10; 2; 3)	Alta. Blue Cross Benefits (1,11,13)	Prescription Drug Plan(1,11)	Pharmacare(1,11)	Ont. Drug Benefit Plan (1,10 & 3)	Drug Plan (2,3 & 5,10)	Prescription Drug Program (2,3)	Pharmacare Plan (2,3)	Financial Assistance Available for Drugs(1,10)	Pharmacare Program(3,10,11)	Yukon Pharmacare(3)	Pharmacare (1)
PROSTHETIC AND ORTHOTIC SERVICES	Basic Health Care Services (4,10)		Sask. Aids to Independent Living(1)	Social Allowances (3,10)	General Welfare Assistance(1,10) Special Assistance to Seniors(3,10)	Que. Health Insurance Plan (1)						
REHABILITATION SERVICES AND OTHER TREATMENT	Aid to the Handicapped(2) B.C. Alcohol & Drug Commission (1) Vancouver Hospice Program (2)	Alta. Alcoholism & Drug Abuse Commission(1) Cancer Services (1)	Sask. Alcoholism Commission(1) Sask. Cancer Foundation(1)	Alcoholism Foundation of Man.(1) Man. Cancer Foundation(1) 1010 Sinclair (rehabilitation) (2)	Palliative Care (cancer-hospice care)(1)	Rehabilitation Services in Reception Centres(3)		Drug Dependency Program(1)	Addiction Services(1) Rehabilitation Program(1)	Alcohol & Drug Addiction Foundation(1) Rehabilitation Centre(1)		Rehabilitation Program(1)

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						HOUSING						
HEATING AND INSULATION PROGRAMS			"Warm-up" Sask. Program(1)	Man. Home Owners' Insulation Loan Program(1,11)	Ont. Temporary Home Heating Grant(3,10) Temporary Home Heating Tax Credit(8,10)			Home Insulation Loan Program(1)			Pioneer Utility Grant(3 & 5,9)	
HOME ADAPTATION PROGRAMS		Home Adaptation Program(2)	Home Adaptation Programs(2) Sheltered Housing Project(1)	Critical Home Repair Program (2)	General Welfare Assistance -Some General Assistance(2,10)			Access a Home Program(2)				
HOUSING INFORMATION		Senior Citizen Housing Registries(3)		Office of the Rentalsman(1)	Community Information Centres(1) Local Housing Authorities(3) Ont. Seniors Secretariat(4)	Municipal Housing Offices(1)						
LOW-INCOME/ PUBLIC HOUSING	Senior Citizens' Housing Construction Program(3,10) Subsidization of Social Housing (1,10 & 3)	Self-contained Apartments(3,10)	Public Housing Program(1,10)	Elderly Persons' Housing Program of Man. Housing & Renewal Corp. (4,10)	Ont. Housing Corp. Apartments(4,10) Public Housing (1,10) Rent-Geared-to-Income for Senior Citizens Program(4,10)	Municipal Senior Citizens' Residences (3,10) Subsidized Housing(1,10)	Public Housing for Senior Citizens (3,10)	Apartment Conversion Program(1) Public Housing (1,10) Rental Assistance Program(1,10) Senior Citizens' Program(3,10)	Senior Citizens' Units(4)	Senior Citizens' Subsidized Apartments(4,10)	Self-contained Apartments(4)	Senior Citizens' Homes(3,10)
NON-PROFIT HOUSING	Provincial Rental Assistance Program(6,10) Rent Supplement for Non-profit Societies(6,10) Residential Subsidy -Glenshiel & Brentwood Houses(6,10)	Interest Subsidies on Loans to Homeowners to Build Rental Suites(1) Senior Citizen Capital Grant Program(3,10)	Co-op Housing(1) Non-profit Housing for Senior Citizens Program (3)	Grants to Non-profit Housing Units(4) Rent Supplement, Elderly & Infirm Persons' Housing(4,10)	Grants to Non-profit Housing Units(4) Limited Dividend Housing (church, ethnic, service club groups) (4,10) Rent Supplementation, Elderly & Disabled Persons' Housing(2,3,10)	Aid to Co-op Housing (1,10) Rental Subsidy Program(1,10)						
RESIDENTIAL REPAIR AND REHABILITATION PROGRAMS		Alta. Pioneer Repair Program (3,10 & 5,9,10)	Residential Rehabilitation Program(1,10) Senior Citizens' Home Repair Program(3)	Critical Home Repair Program -Low-income Families' Program(8,10) -Pensioners' Program(3,10)	Ont. Home Renewal Program(1,10)	Home Restoration Aid(1,10)	Home Improvement Loans for Senior Citizens (4,10)	Provincial Housing Emergency Repair Program (1,10) Senior Citizens' Assistance Program(3,10) Small Loans Assistance Program(1,10)	Provincial Contribution to Seniors for Materials(4,10)	Community Development Program(4,10) Programs in Native Communities(2)	Dwelling Restoration Program(1,10)	

PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO	QUEBEC	NEW BRUNSWICK	NOVA SCOTIA	PRINCE EDWARD ISLAND	NEWFOUNDLAND	YUKON TERRITORY	NORTHWEST TERRITORIES
INSTITUTIONAL CARE												
INSTITUTIONAL CARE*	Long-term Care Program -Extended Care Hospitals (1,11) -Government Hospitals (1,11) -Other Institutions (1,11)	Alta. Nursing Home Program (1,11) Auxiliary Hospitals(1,11) Extended Care Centres(1,11) Homes for Special Care (deficit funding)(3,11) Lodge Program (3,11)	Construction Grants for Special Care Homes(1,11) Government-funded Special Care Homes(1,11) Level IV Care(1) Personal Needs Allowance for Residents in Special Care Homes(2)	Adult Foster Homes(3,11) Extended Treatment Hospitals/Units (1) Personal Care Home Program (1,11) Residential Care Facilities (licensure only)(2,3,11) -Social Allowance for Residents (2,3)	Adjuvant Program (4) Chronic Hospital Care(1,11) Extended Health Care Program (1,11) Homes for the Aged(4,10) Homes for Special Care (ex-psychiatric) (1) Nursing Homes (1,11) Satellite or Foster Homes (4,11)	Foster Families (3) Long-term Care Hospitals(1) Pavillions(3) Reception Centres(3,11)	Extended Health Care(1) Foster Homes Program(1) Nursing Home Services Program(1,11) Special Care Homes(1)	Homes for Special Care -Homes for the Aged(3) -Nursing Homes(1) -Residential Care Facilities(1)	Chronic Care Unit(1,11) Nursing Homes (4,11) Provincial Homes for the Aged (manors)(4,11) Special Boarding Homes(1)	Government Homes for Special Care (1) Interfaith and Church-operated Homes(1) Licensed Boarding Homes(1)	2 Lodges(1) Type I & II Care(1)	Extended/Chronic Care Units(1) Nursing Homes (1,11) Personal Care Units(3,11)
OTHER, INCLUDING LABOUR AND EMPLOYMENT												
EMPLOYMENT SERVICES**		Edmonton & Calgary Senior Centres(3) "Over 45" Program (Edmonton & Calgary)(7)		Senior Citizens' Job Bureau (4)	Sheltered Workshops (1,11) Special Counselling(6)							
HUMAN RIGHTS	B.C. Human Rights Commission(1)	Alta. Human Rights Commission(1)	Sask. Human Rights Commission(1)	Man. Human Rights Commission(1) Ombudsman(1)	Ont. Human Rights Commission(1)	Que. Human Rights Commission(1)	N.B. Human Rights Commission(1) Ombudsman's Office(1)	N.S. Human Rights Commission(1)	P.E.I. Human Rights Commission(1)	Nfld. & Labrador Human Rights Commission(1) Omudsman(1)		
PENSION INFORMATION SERVICES				Pension Commission of Man.(1) Women's Bureau (1)	Ont. Seniors Secretariat(4) Pension Commission of Ont.(1)							

* Including nursing homes, homes for the aged, long-term care hospitals, etc.

** Including apprenticeship programs.